# Practice Guide: Standards and Practice Regarding the Health Care of Children in DCF's Care

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# REQUIRED HEALTH CARE AND STANDARDS

**Purpose**

The purpose of this Practice Guide is to promote child health and well-being and to identify significant medical, dental, mental, behavioral, emotional (including exposure to traumatic events), developmental and school problems; to monitor for signs or symptoms of abuse or neglect; and to provide age-appropriate anticipatory medical and mental health guidance.

## Initial Medical Evaluation

**Introduction**

Each child placed in an out-of-home placement shall, within 72 hours of removal, receive an initial medical screening evaluation to identify if he or she has an acute medical or mental health care need or has a chronic medical or mental health condition which requires medication.

**Purpose of Initial Health Screening**

The purpose of the initial health screen is to:

- identify any acute medical, dental or urgent mental health needs and to assure the timely provision of necessary treatment;
- ensure the child has medications or treatments needed for any chronic medical or mental health conditions;
- document the presence or absence of medical or mental health problems;
- identify signs and symptoms of maltreatment including physical, sexual and emotional abuse and neglect, and child traumatic stress symptoms;
- assess for any infections or communicable diseases; and
- provide the Social Worker with developmental information including an understanding of the types of additional services and interventions needed to assist with case planning decisions to meet the health and well-being of the child.

**Exceptions**

A child who is placed directly from a hospital setting or a physician's office where a comprehensive initial screen was performed does not require an initial health screening provided that he or she has received all necessary treatments for acute problems during this period. Records of these treatment encounters shall become part of the child's DCF medical record.

**Who May Conduct an Initial Medical Screen**

An initial health screening examination shall be performed by a qualified physician or nurse practitioner. It is preferable for the child to receive an initial screening by his or her primary care provider or the intended provider of on-going medical care.

The child's designated health care provider (primary care provider or medical home) should be knowledgeable about the treatment of children in foster care and willing to arrange for the provision of regular, ongoing primary care services.

**Consent**

The DCF-460a, "Authorization for Routine Care," is used to provide consent.

**Where May a Screening be Conducted**

An initial health screening examination shall be performed in a:

- clinic;
- private office; or
- hospital.

To minimize stress to the child and to maintain continuity for routine primary care, an initial screen should occur, when possible, at the child's regular source of primary care or at the clinic or site which will be assuming care.

Whenever possible, someone familiar to the child, preferably of his or her choosing, should attend the appointment.

**Components of the Initial Screening**

The initial health screening shall consist of:

- a review of available medical, developmental and mental health and psychiatric history including any trauma history or trauma screens, drug or alcohol history, and past and current psychiatric medications;
- a review of systems;
- a symptom-targeted examination including vital signs, height, weight, body mass index (BMI), and a complete physical exam including external full body inspection to identify recent or old trauma, bruises, scars, deformities or limitations in the function of body parts or organ systems and to assess chronic conditions;
- developmental and mental health screen for significant developmental delay, suicidal thoughts, major depression or violent behavior as well as to assess for risky sexual behavior, risk of antisocial behavior, attachment or relationship issues, or any other factors that may pose a risk for placement disruption;
- consideration of any emotional trauma associated with maltreatment and the removal from the home;
- review of the child's initial adjustment to placement;
- recommendations, special care instructions and follow-up including all necessary referrals for specialized evaluations;
- follow-up referral to primary care provider if he or she is not performing the initial screen; and
- completion of the DCF-742, "Report of Health Care Visit," where needed, and recommended plan and schedule for ongoing monitoring.

## Multidisciplinary Evaluation (MDE)

**Introduction**

Each child placed in out-of-home care shall, within 30 days of such placement, receive a trauma-informed Multidisciplinary Evaluation (MDE), the purpose of which is to screen the multiple dimensions of a child including the:

- physical;
- dental;
- developmental;
- educational;
- behavioral;
- emotional; and
- child traumatic stress components.

Children who re-enter care will have another MDE performed unless the Area Office determines that a repeat MDE is unnecessary and an exemption is granted.

Children who are placed through the Voluntary Services Program and for whom parents have given consent will also receive an MDE.

**Purpose**

A complete screen shall be performed by a contracted Multidisciplinary Evaluation site to identify, assess and recommend treatment for any acute or chronic medical, educational, developmental, dental or behavioral health condition in a child placed outside of his or her home and identify any child who could benefit form a more comprehensive trauma-focused assessment.

The Area Office staff, in conjunction with the child's primary care provider, will arrange for the provision of regular, follow-up and ongoing primary care services.

**Exemptions**

The expectation is that a Multidisciplinary Evaluation will be performed consistent with the standards described above.

In the rare case of an exemption, the DCF Area Office is still responsible for collecting information similar to that required of the MDE clinic including information about screens for medical, behavioral health, development, dental and educational issues.

Exemptions:

- may be granted by a Program Manager in consultation with the RRG Nurse or Nurse Practitioner; and
- shall be documented in the managerial conference note as to why the child is exempt. Documentation must also include details of an assessment of potential emotional trauma associated with the child's removal.

**Exemptions to MDEs being Performed within 30 Days at MDE-Contracted Clinics**

The following children are exempted from having a MDE performed at a contracted clinic within 30 days of placement:

- newborn infants placed directly from a hospital;
- children who are placed in detention for more then 30 days and have documented medical, behavioral health, development, dental and educational assessments;
- children placed directly into or from a DCF facility (Solnit Center, CJTS) and for whom DCF has documented medical, behavioral health, development, dental and educational assessments;
- children placed in group homes or residential settings that have a contracted responsibility to complete a MDE; and
- children who are re-entering DCF care and have previously had an MDE, and for whom the Program Manager determines a repeat MDE is unnecessary.

**Re-Entry into DCF Care**

If a child re-enters care and it is determined that an MDE is not necessary, the following steps must be taken:

- a routine health examination including lab studies and immunizations, if needed, completed within 30 days by a primary care provider; and
- a comprehensive Health Plan developed based on recommendations from the above exam and any other medical assessments.

RRG Nurses or Nurse Practitioners will assist the Social Workers in obtaining this information if it is not otherwise provided.

**Delays**

The expectation is that the MDE will occur within 30 days of a child entering care.

In the rare event that a delay of the MDE is needed, the Program Manager shall document in the MDE icon the reason for the delay and projected deadline for its completion.

Updates on scheduling and completion shall be documented in LINK weekly until the MDE is completed.

**Who May Conduct a MDE**

Multidisciplinary Evaluations may only be conducted at DCF-contracted MDE sites by licensed DCF-contracted providers.

**Components of the MDE**

DCF shall require contracted MDE providers to include the following components in all MDEs:

- review of all available past medical, behavioral health, social and trauma history at or prior to clinic visit;
- complete medical examination including vital signs, height and weight, BMI%, hearing and vision screens;
- developmental assessment that includes the use of approved MDE tools (unless child is already being seen by Birth to Three or DCF has documentation of recent involvement with Birth To Three);
- behavioral health assessment, mental status exam and diagnostic formulation that includes the use of approved MDE tools;
- complete dental screening; and
- documentation of any trauma exposure history and any current child traumatic stress symptoms, as well as administration of the Connecticut Trauma Screen for those children ages seven and above.

**Note**: The MDE does not take the place of routine EPSDT exams.

**Consent**

Consent from a parent is required for any child for whom the Commissioner is not the legal guardian (most children getting MDEs will not be committed to DCF).

Once it is known which MDE clinic will be seeing the child, the Social Worker who removed the child shall obtain the signed DCF-MDE-460,"Permission to Conduct a Multi-Disciplinary Evaluation and Release of Information."

Prior to obtaining consent, the Social Worker shall provide the parent or guardian with the MDE informational material describing the MDE clinic, its purpose and importance, and discuss any questions.

If a parent is not available to provide consent or will not sign consent at removal, the MDE consent should be reviewed at the ten day hearing in court and consent from the parent or guardian obtained at that time.

If the parents are still refusing to sign or cannot be located and the OTC is sustained by the court, the Program Manager may sign the consent for the MDE and document in LINK why the parents did not sign and what efforts were made to secure their consent.

(**See** MDE Report section of this Practice Guide for details about adolescent consent required for release of information to DCF about any disclosures of substance use or reproductive health issues.)

**Procedure upon Placement**

At the time of placement, the Social Worker shall provide the foster parent or placement provider with the pamphlet describing the MDE and will review the MDE process and its importance. (Education about the MDE should have occurred in PRIDE or other training.)

The FASU matcher (or other designated staff) in the Area Office shall complete Section I - Part A of the MDE Report template (DCF-746).

The FASU matcher shall email the MDE referral (page 1 of the MDE Report) to the MDE clinic and copy the Social Worker, Social Work Supervisor, FASU Support Worker, Healthcare Advocate and RRG Nurse or Nurse Practitioner on the email. In the email "subject" line, the Social Worker shall write "[secure] MDE Referral - _____ (child's last name), (placement date)."

The Health Advocate shall check the referral (DCF-746) to ensure that Section I - Part B (insurance information), primary care provider information (PCP name, phone number, date of last visit) and dental information (dentist name, date of last exam) are documented on the MDE Report template. The Health Advocate shall provide or correct the child's name, date of birth, Medicaid or private insurance information and any missing PCP and dental information in the email.

The Health Advocate shall forward the MDE Report template to the appropriate MDE clinic, assigned Social Worker, Social Work Supervisor and FASU matcher (or other designated staff).

The MDE clinic coordinator or designee will schedule the MDE appointment with the foster parent or other caregiver. If the foster parent or other caregiver is not available, the clinic coordinator or designee will schedule the appointment with the Social Worker who knows the child best. The clinic coordinator or designee will review the pamphlet and review purpose of MDE with the foster parent or other caregiver.

When children are placed outside of the Region, the Area Office chain of command, with assistance from the Health advocate ***and*** in collaboration with the MDE Clinic, shall decide where the MDE will be performed. Once the site is determined, the Area Office will request that the Health Advocate send the referral to the MDE clinic of choice.

The MDE clinic coordinator or designee will send an email to the Social Worker, Social Work Supervisor, RRG Nurse or Nurse Practitioner and FASU support worker with the date and time of the MDE and attach the sections to be completed by the Social Worker along with the consent form.

The Social Worker who had the case at the time of removal shall complete section I, Parts C, D, E and F of DCF-746 and fax or email (using the secure email system) the information to the MDE clinic along with the signed DCF-MDE-460 at least five days before the MDE appointment.

The RRG Nurse or Nurse Practitioner shall assist the Social Worker as needed in obtaining the child's medical and behavioral health history in order to complete the MDE packet (Parts C, D, and E).

**Day of the MDE Appointment**

A person familiar with the child, preferably the foster parent or assigned Social Worker and, if appropriate, the biological parent, shall accompany the child to the MDE visit and meet with MDE staff

**Medical Component of MDE Process**

**Purpose:** To identify any medical conditions and review any available data and medical history about the child.

**Qualifications of evaluator:** a pediatrician, pediatric APRN, family physician or family nurse practitioner (all are knowledgeable about the unique needs of this population).

**Components include:**

- review of systems including allergies;
- complete unclothed physical exam (vital signs as appropriate for age including OFC, height, weight and BMI% with graphing on age appropriate charts) that is conducted in a trauma-informed manner.
- **See** Centers for Disease Control BMI calculator: http://www.cdc.gov/healthyweight/assessing/bmi/;
- immunization review;
- medication review;
- hearing and vision screening, with referral if needed;
- anticipatory guidance;
- review of universal precautions; and
- recommendations for referrals as needed.

If while examining the child, the provider has questions or identifies urgent or emergent issues, he or she, or the clinic coordinator, will follow up with the child's primary care provider.

**Behavioral Health, Developmental and Educational Component of MDE**

**Purpose:** To determine whether there is a need for a full examination for disorders common in this population including those relating to:

- fetal alcohol and drug exposure;
- substance abuse;
- trauma;
- behavioral health; and
- behavioral challenges.

Attention will also be paid to identification of children who require immediate behavioral health intervention.

**Qualifications of evaluator**: masters-level or above licensed behavioral health clinician with formal training in the administration, scoring and interpretation of the tools being utilized.

**Behavioral Health, Developmental and Educational Component of MDE (continued)**

An exception may be granted to allow qualified unlicensed individuals (*e.g.,* post-doctoral students) to perform the behavioral health, developmental and educational components if:

- DCF grants an exception;
- the unlicensed provider is supervised by a licensed clinician; and
- the licensed clinician also signs the Summary and Recommendations section of the report.

**Components include:**

- complete developmentally-based mental status exam;
- review of trauma history exposure and any current child traumatic stress symptoms;
- standardized measures as identified by DCF;
- assessment of school issues to attempt to define whether there is a need for follow up in specific areas (*e.g.,* need for additional information if the problem presents in the school setting, need to request a team meeting or PPT to secure additional support in school);
- collateral interviews with adults (DCF Social Worker, foster parent, biological parent) in person or on the phone limited to brief questions about strengths and areas of concern; and
- recommendation(s) for referral(s) as needed.

**Behavioral Health, Developmental and Educational Screens to be Conducted**

| Measure | Domain: What needs are being identified | Age Range |
|---|---|---|
| Peabody Picture Vocabulary Test-Fourth Edition (PPVT-4) | Cognitive: Verbal | 2 years-6 months to adult |
| Test of Non-verbal Intelligence-Fourth Edition (TONI-4) | Cognitive: Non-Verbal | 6 years to adult |
| Ages and Stages Questionnaire (ASQ) - 3 | Developmental-General | 1 to 66 months |
| Battelle Screen (portions as needed at evaluator's discretion if ASQ not felt to be valid or complete) | | 0-8 years |
| Ages and Stages Questionnaire: SE | Developmental: Social-emotional | 3-66 months |
| M-CHAT | Developmental: Autism Spectrum | 16-30 months |
| BASC-II Parent | Behavioral: Pre-school | 2-5 years |
| BASC-II Parent | Behavioral: Child | 6-11 years |
| BASC-II Parent | Behavioral: Adolescent | 12-21 years |
| BASC-II Self Report | | 6-25 years |
| GAIN Short Screener (domain 3 only) | Substance Abuse | 12 years to adult |
| Mental Status Exam | General | All |
| Connecticut Trauma Screen | Trauma History | Ages 7 to adult |

**Trauma Screen Component of MDE**

**Purpose**: To identify children who may benefit from a more comprehensive trauma-focused assessment by a trained clinician.

**Qualifications of evaluator**: a masters-level or above licensed behavioral health clinician with basic training in child traumatic stress, how to use the trauma screen to engage children and caregivers, and how to manage responses and disclosures of trauma.

An exception may be granted to allow qualified unlicensed individuals (*e.g.,* post-doctoral students) to perform the behavioral health, developmental and educational components if:

- DCF grants an exception;
- the unlicensed provider is supervised by a licensed clinician; and
- the licensed clinician also signs the Summary and Recommendations section of the report.

**Components Include:**

- Connecticut Trauma Screen - Child Report (Age 7+);
- review of trauma history exposure and any current child traumatic stress symptoms; and
- recommendations for referral as needed.

**Dental Health Component of MDE**

**Purpose:** To identify urgent and ongoing dental needs.

**Qualifications of evaluator**: dentist; public health dental hygienist; or a provider certified in the DSS-certified "Open Wide" curriculum.

**Components include:**

- oral assessment (dental decay, gum health); and
- recommendation(s) for referral(s) as needed.

**MDE Clinic Responsibilities Following the Evaluation**

Following an evaluation, the MDE clinic will:

- work with the Area Office to develop a plan for follow up including mechanisms for reviewing decisions about recommendations;
- hold an MDE team meeting to discuss the child's status and to identify any urgent needs that require immediate attention;
- if emergent needs are identified (while or immediately after attending to the needs of the child), the MDE clinic coordinator or provider will contact the RRG Nurse or Nurse Practitioner and utilize the chain of command to alert DCF immediately (an email documenting the emergent need must be sent to the Social Worker, Social Work

**MDE Clinic Responsibilities Following the Evaluation (continued)**

Supervisor, RRG Nurse or Nurse Practitioner and Behavioral Health Program Manager within two hours and must contain specific information about the emergent need and where the child was sent);

- if urgent needs are identified, the MDE clinic coordinator or provider will contact the RRG nurse and utilize the chain of command to alert DCF within 48 hours (an email documenting the urgent needs must be sent to the Social Worker, Social Work Supervisor, RRG Nurse or Nurse Practitioner and Behavioral Health Program Manager within 48 hours and contain specific information about the urgent need and any steps taken;
- fax or email the completed Trauma Screen to the identified fax or secure email contact located at the bottom of the Connecticut Trauma Screen;
- when requested, ensure that the clinic coordinator will be available to attend the Case Planning Conference in person or by phone; and
- at the end of each MDE clinic day, the MDE clinic coordinator will email a list of children who had MDEs completed that day to the identified DCF liaison.

**DCF Responsibilities Following the Evaluation**

Following an evaluation, DCF will:

- follow up on urgent and emergent needs within specified timeframes; and
- enter the location and date the MDE occurred in LINK within two days of the MDE.

**MDE Report**

The completed MDE report will be provided to DCF for each child referred for services. This report will:

- follow the required DCF template (DCF-747);
- include a comprehensive summary report of findings for medical, dental, developmental, behavioral health, educational and trauma screen components of the MDE with a "needs" list, recommendations for addressing each problem and timeframes for completion;
- include guidance around developmental issues for children up to three years of age based on performance on the Ages and Stages Questionnaire and other developmental assessment (if this includes a Birth to Three referral, it should be indicated on page 4 of the "Summary and Recommendations" section of the MDE Report, DCF-747);
- be submitted to DCF within two weeks of the MDE visit;
- be emailed by the MDE clinic to the Social Worker, Social Work Supervisor, RRG Nurse or Nurse Practitioner, FASU support worker, Behavioral Health Program Director, Quality Assurance Program Director or Manager, the identified DCF MDE liaison and clerical support.

The assigned Social Worker will print out the electronically-sent MDE report and place it in the case record.

**MDE Report (continued)**

The Area Office will send a copy of the "Summary and Recommendations" sections to the child's primary care provider and foster parent or placement provider within five days of receipt of the complete MDE report.

**Child Permission to Release Information**

When a Multidisciplinary Evaluation is performed on a child aged 13 to 17 years, the MDE clinic must obtain a signed DCF-460-MDE-A, Multidisciplinary Evaluation Child Permission for Release of Information. This gives the clinic permission to disclose to DCF information pertaining to substance abuse (alcohol or drug use and treatment) and reproductive health (sexual activity, sexually transmitted diseases and birth control).

**Area Office Follow Up and Care Planning**

Each Area Office will develop procedures to ensure the following occur:

- there is an identified MDE liaison in each Area Office;
- the MDE reports are reviewed by staff familiar with the child;
- a plan is developed for responding to each recommendation made in the MDE report that includes specific steps, time frames and the name of the persons responsible;
- immediate referrals to Birth to Three are made if recommended by the MDE clinic;
- a manager reviews the "Summary and Recommendations" section of the MDE report prior to its distribution to the primary care provider and foster parents;
- the "Summary and Recommendations" section is reviewed with the child's foster parent or placement provider;
- the child is referred to an RRG clinician or to DCF Regional Education Services when needed;
- recommendations that are not accepted are reviewed with the MDE clinic;
- consultation with the Health Advocate when needed to:
  - assist in resolving problems that arise which prevent access to timely healthcare services that are needed; and
  - inform the DCF Social Worker and, when needed, other Area Office staff of the outcomes after the consultation;
- dissemination of the MDE "Summary and Recommendations" to additional stakeholders as appropriate *(e.g.,* child's attorney);
- incorporation of the MDE recommendations into the 60 day Case Plan;
- discussion and documentation of progress on each of the MDE recommendations at the six-month ACR and at subsequent ACRs until the recommendation(s) are completed;
- consultation with the RRG Nurse or Nurse Practitioner and RRG clinician when needed prior to the six-month ACR to review any unmet medical or behavioral health recommendations; and
- consultation with the Health Advocate when needed prior to the six-month ACR to resolve unmet needs that are due to lack of access to health care services.

**MDE Quality Improvement and Evaluation**

Quality improvement and evaluation of MDEs will occur as part of contracting process at Central Office and at the Regional or Area Office level.

Components of MDE quality improvement and evaluation will include quarterly meetings between MDE providers and the Area Offices, yearly audit meetings, and implementation of tools which will monitor process and outcome measures incorporating Results-Based Accountability (RBA).

Mechanisms for the collection of data will include customer and consumer satisfaction surveys, audits and chart reviews.

**Note:** The MDE liaison acts as the main contact person for MDE questions and concerns for both the Area Office staff and the MDE clinic. This person assists in the development and implementation of the MDE protocol and also provides on-going monitoring of the established process. The MDE liaisons are actively involved in the MDE quality improvement and evaluation process including collection and review of MDE data and coordination of weekly and bi-annual meetings with MDE clinics and the Area Office to discuss quality improvement activities.

**Quarterly Meeting with Area Office and MDE Clinic**

The Area Office shall arrange for quarterly meetings with MDE clinics to discuss issues related to the MDE process to include but not be limited to:

- how the process is going;
- communication;
- quality of the reports;
- outstanding MDE components; and
- any other issues that require addressing

**Yearly Audit Meetings**

The DCF MDE program leads and the MDE audit workgroup (representatives from the larger MDE workgroup) will arrange for a yearly audit meeting to discuss quality assurance and improvement topics and to review MDE functioning including specific Area Office and MDE roles and responsibilities and components outlined in this Practice Guide regarding performance and practice.

**RBA Performance Measures**

Specific RBA performance measures identified to evaluate the program's effectiveness include the following:

| How much did we do? | How well did we do it? | Is anyone better off? |
|---|---|---|
| • # of physical exams<br>• # of dental exams<br>• # of mental status exams<br>• # of age- specific screenings<br>• # of behavioral health assessments<br>• # of Connecticut Trauma Screens completed<br>• #of MDE reports generated<br>• # of MDE "team" meetings held ("team" is identified as the MDE clinic team) | • % of properly credentialed practitioners<br>• % of age-appropriate screenings<br>• % of reports completed within timeframe<br>• % of fully completed forms<br>• % of reports submitted to DCF within timeframe<br>• % of consumer satisfaction surveys completed | • Does DCF have the necessary information to develop a high quality treatment plan?<br>• Results of required data and outcome requirements |

## Health Supervision and Well Child Care

**Purpose**

Children in out-of-home care shall receive health supervision and well-child care including prevention services consistent with Early Periodic Screening, Diagnosis and Treatment (EPSDT). Immunizations shall be provided consistent with the guidelines and schedules of the Advisory Committee on Immunization Practices (ACIP).

**Components of Care**

Standard health supervision and well-child care shall include:

- routine and preventative care consistent with "Bright Futures: Guidelines for Health Supervision of Infants, Children & Adolescents" (http://brightfutures.aap.org/3rd_edition_guidelines_and_pocket_guide.html and Fostering Health: Health Care for Children and Adolescents in Foster Care, 2nd Edition, Task Force on Health Care for Children in Foster Care, American Academy of Pediatrics (http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/FosteringHealthBook.pdf); and
- immunizations based on guidelines and recommendations of the ACIP (CDC - Vaccines - Immunization Schedules main page)

**Process**

Routine scheduled health supervision and well child care, including an age-appropriate review of systems, screening consistent with best practices and, as needed, physical examination, mental health status examination and anticipatory health guidance, shall be conducted by the child's health care provider.

The child's Social Worker or foster parent shall accompany the child to each appointment.

The Social Worker or foster parent shall request that the health care provider complete the DCF-742, "Report of Health Care Visit."

The Social Worker shall ensure that any recommendations are discussed with the child, foster parent and biological parents, if appropriate.

The Social Worker shall ensure that recommended lab studies are arranged and referral appointments or follow-up visits are scheduled.

The Social Worker and the foster parent shall each retain a copy of the DCF-742.

The Social Worker shall enter the information into the LINK medical narrative and if needed, update the LINK Medical Alert, the Health Passport Health Summary (DCF-741HS) and Comprehensive Health Plan of the child's case plan with help from the RRG Nurse or Nurse Practitioner.

(**See** this Practice Guide, Health Information and Documentation section for guidance.)

## Comprehensive Health Plan

**Introduction**

The case plan shall include a comprehensive Health Plan inclusive of medical, dental, and behavioral and emotional health. The initial comprehensive Health Plan is developed as indicated below based on MDE recommendations with review as part of the case plan at the 45 day treatment planning conference and at each subsequent ACR.

**Purpose**

To summarize a child's health issues and document plans for ongoing care including required interventions and routine care.

By documenting and tracking of all aspects of the Health Plan including appointments, health visit outcomes and recommendations, the Area Office will ensure that child is receiving appropriate care and services.

**Who Develops the Comprehensive Health Plan**

The RRG Nurse or Nurse Practitioner, working with the Social Worker and foster parent or other caregiver, in collaboration with a child's health care provider, and with assistance from other DCF medical staff as needed, shall develop the Health Plan.

**Content**

The Health Plan should include recommendations from the MDE and a summary of medical and mental health conditions, with recommendations for ongoing case intervention and follow up.

The Plan should be revised as needed to ensure up-to-date information and treatment details.

**Process**

The RRG nurse and Social Worker will develop the Comprehensive Health Plan and integrate into the case plan.

The comprehensive Health Plan shall be discussed at the ACR and ongoing case conferences with updates monthly as needed.

The Health Plan shall be routinely updated by RRG Nurse or Nurse Practitioner and Social Worker based on reports of health visits and other information obtained.

## Monitoring and Tracking

**Purpose**

Ongoing monitoring of health care including health supervision and completion of recommendations will occur for all children. This will be achieved through periodic assessment of the "Health Summary" (DCF-741), "Report of Health Visits" (DCF-742) and review of LINK and the comprehensive Health Plan.

**Purpose (continued)**

Frequency of review including visits, supervision and follow up with the health care provider and other referrals recommended in the initial health screen and MDE will be determined at the initial visit and after each ACR.

The schedule will be based on the child's health needs.

There may be an occasional situation when an adolescent refuses to obtain medical, dental or mental health care following an explanation of the needs, benefits and risks of no care by the DCF Social Worker or the RRG Nurse or clinical consultant. Whenever this occurs, full documentation of the discussions with the child and the outcomes of those discussions must be documented.

## Discharge from Care

**Purpose**

Prior to discharge from DCF care, a child and his or her parents or legal guardian shall be provided with an up-to-date "Health Summary" (DCF-741) including recommendations for ongoing medical and mental health care and contact information for the primary care provider or medical home (referred to as the "health care provider" in this Practice Guide) as well as any specialty providers who will be providing ongoing care to the child after discharge.

**Who Develops the Discharge Health Summary**

A RRG Nurse or Nurse Practitioner, working with the Social Worker, shall update the health summary in collaboration with the child and his or her health care provider and parent or guardian.

**Process**

The Social Worker shall inform the child's current health care provider of the plan to discharge the child from DCF care.

Reasonable efforts shall be made to maintain the same health care provider if appropriate. If the health care provider needs to change, the child's case plan shall be shared with the current health care provider so that a new provider can be identified, in consultation with the parent or legal guardian to whom the child will be discharged. DCF staff shall encourage current and successor health care providers to communicate directly about concerns or ongoing medical or mental health care needs whenever possible.

The Social Worker, with assistance from the RRG Nurse and Nurse Practitioner and the Health Advocate, if appropriate, shall be responsible for assisting the family with identifying a new provider. A summary of the child's health care and recommendations shall be forwarded to the successor health care provider.

Once updated, the medical and mental health information and recommendations shall become part of the child's case record, entered into LINK and the Health Summary.

## Hospital Support and Visitation Plan

**Purpose**

On the rare occasions that a child is hospitalized, it is essential that he or she receive support from individuals with whom the child has a relationship. DCF is responsible for partnering with foster families, biological families, caregivers and other resources to develop an ongoing plan for visitation and support responsive to a child's individual needs.

**Goal:** Provide children in DCF care with the support they need during hospitalizations and ensure that appropriate documents are entered in the child's LINK record.

Whenever a child in DCF's care is hospitalized, a formal plan for support and visitation must be developed and implemented within two business days of admission for unplanned or emergency admissions and at the time of admission for planned admissions.

The plan will be informed by appropriate medical, mental health and clinical consults involved in the child's care and the nature of the child's primary relationships and existing supports. The assigned Social Worker and Social Work Supervisor are responsible for the formulation, execution and documentation of the plan (DCF-462, "Hospital Support and Visitation Plan").

**Planned Hospitalizations**

A Hospital Support and Visitation Plan should be developed in advance of the hospitalization and implemented upon admission.

**Unplanned and Emergency Admissions**

A DCF Social Worker should go to the hospital to see the child at the time of admission but no later than the end of the same day. (This applies to emergency admissions and not to the Emergency Department itself where a child must have supervision and support at all times.)

A "Hospital Support and Visitation Plan" (DCF-462) must be developed and implemented within two business days of admission.

Upon receiving the information of an **after-hours admission** to the hospital (weekends and holidays), Careline will contact the foster parents or facility where the child is placed to ensure that the child is provided with adequate support and visitation during the hospital stay. If no supports are available at the time of admission, the Careline will dispatch an on-call Social Worker to visit the child.

Further visits will be determined by Careline after an assessment of available resources. Careline will also promptly inform the Area Office Director of the child's admission. The Area Office will begin development of the Hospital Support and Visitation Plan the next business day.

**Process for Developing a Hospital Support and Visitation Plan**

The Social Worker and Social Work Supervisor, FASU Social Worker and Supervisor and RRG staff will meet to discuss the child and the current hospitalization. The child's attorney should be invited. Topics should include:

- reason for admission and anticipated treatment or procedure;
- child's needs (both emotional and safety);
- child's baseline medical and mental health;
- anticipated duration of stay;
- available resources including foster and biological family members, other significant people in the child's life, DCF and other professionals known to the child;
- any visitation restrictions;
- legal status; and
- plan for continuation of child's pre-hospitalization medication regimen, including continuation of psychotropic medication and a plan for support of the child if medication is discontinued during hospitalization.

The RRG Nurse or clinical social worker should speak with the hospital medical provider to gather details including the extent of treatment or procedure and post-operative and hospital course.

Following this meeting, designated staff will follow up with the specific resources identified. Resources will vary depending on the specific needs of the child. (Assessment of the needs of the foster family or other caregiver should also occur if there are other children in the home. Those children's Social Workers should also be involved to support the caregiver.)

The biological family should be involved in the development of the visitation plan if appropriate. If not, the Social Worker will determine how the biological family can be included (*e.g.,* visits, phone contact) and the need for supervision of the visitors.

Resources to consider for visitation and support include:

- the foster parents or other caregivers and their extended families;
- biological parents and their extended family; and
- other significant people in the child's life (*e.g.,* mentors, coaches, teachers, supports through church, baby-sitters, daycare staff, DCF).

The hospital social worker, nursing and medical providers must be consulted and their input included in the development of the plan.

The plan will establish the amount of visitation required each day for the child based on his or her needs and wishes.

The Visitation and Support Plan shall be reviewed and revised as needed based on the child's condition, associated needs, wishes and change in medical status. Any changes must be reviewed with the Social Work Supervisor.

**Process for Implementation of the Completed DCF Hospital Support and Visitation Plan (DCF-462)**

The completed written plan (DCF-462, "DCF Hospital Support and Visitation Plan") will be:

- documented in LINK in the medical narrative and the supervisory note;
- provided to the hospital and placed in the child's chart;
- reviewed with the hospital social worker, nursing manager and medical provider;
- sent to the DCF Chief of Pediatrics (email or fax 860-723-7236); and
- made available to the child's foster parent or other caregiver.

**Components of the written DCF Hospital Support and Visitation Plan (DCF-462)**

The DCF Hospital Support and Visitation Plan (DCF-462) shall include:

- the schedule for visitation (*e.g.,* daily, every other day);
- the DCF staff scheduled for visitation (*e.g.,* Social Worker, RRG Nurse or Nurse Practitioner);
- foster parents', biological parents', siblings' and other resources' schedule for visitation;
- DCF daily phone contact plan (this will occur at an agreed-upon time with the hospital provider to receive updates about the child's status);
- a list of individuals other than DCF who can visit;
- a list of individuals who cannot visit;
- any restrictions on visitation and, where needed, a plan for accompanying individuals during supervised visits;
- any restrictions on telephone contacts;
- plan for continued mental health treatment, if necessary; and
- contact information for Social Worker, Social Work Supervisor, RRG Nurse or Nurse Practitioner, Program Manager, Area Office Director, foster parent or other caregiver, biological parent, child's attorney and the DCF Chief of Pediatrics.

## Medical Review Board

**Purpose**

The Medical Review Board (MRB) is established by the Commissioner of the Department of Children and Families (DCF).

The MRB shall make recommendations to the Commissioner or designee in matters concerning the medical care and treatment of children in the care and custody of DCF when their health situations are exceptionally complex or present other ethical or legal issues.

**Composition of Medical Review Board**

The Medical Review Board's standing members, appointed by the Commissioner, shall include:

- the DCF Chief of Pediatrics (chairperson);
- the DCF Chief of Community Psychiatry;
- the DCF Director of Early Childhood Child Welfare or designee;
- the Agency Legal Director or designee;
- a pediatric intensive care specialist, preferably board certified in critical care medicine;
- a community-based, board-certified child and adolescent psychiatrist;
- a board-certified pediatrician or APRN skilled in the care of children with complex medical needs;
- a board-certified pediatric neurologist; and
- a biomedical ethics expert.

**Medical Review Board Coordinator**

There shall also be an MRB Coordinator who, as a DCF employee, works under the supervision of the chairperson. The Coordinator shall have familiarity with medical, social and legal issues faced by DCF's client population. The Coordinator shall not be a voting member of the MRB.

**Note:** A single MRB member may fill more than one of the designated specialties. The Chairperson shall designate the DCF Medical Director or another alternate to act as the chairperson in the chairperson's absence. Reasonable efforts shall be made to ensure MRB member representation from throughout the State of Connecticut.

**Selection of Case-Specific or Ad Hoc MRB Members**

In addition to the standing members of the Medical Review Board, the chairperson may, as necessary for a specific case, add case-specific or ad hoc members to the MRB to inform the specific individualized questions relevant to the case being considered.

The designation of Medical Review Board members for any individual case shall be made by the chairperson with consideration of the unique elements of each situation.

**Administration**

The Medical Review Board shall be administered by the DCF Chief of Pediatrics. The Medical Review Board shall convene twice a year to review outcomes and, if needed, address any needed changes to policy and procedures. Following each semi-annual meeting, the Chief of Pediatrics shall send a report to the Commissioner which shall include statistics and recommendations for improvement of policy and procedures.

**Authority of MRB to Review Cases**

The MRB shall review cases involving any child committed to DCF as abused, neglected or uncared for and any child for whom the Commissioner is the statutory parent.

The MRB may review cases involving a child who is committed delinquent or FWSN, or is in the care and custody of DCF as a Voluntary Services client or on an Order of Temporary Custody.

**Note:** If the MRB declines to review the case of a delinquent, FWSN committed, Voluntary Services client or child on an OTC, the Coordinator shall so inform the requestor and provide guidance regarding the requestor's next steps.

**When to Make a Referral to the MRB**

The Area Office Social Work or Juvenile Justice staff shall refer a case to the Medical Review Board when:

- authorization is being sought for medical or surgical treatment of a child that is exceptionally complex, high risk, unusual or complicated by ethical or legal issues, as determined through consultation with the RRG Nurse or Nurse Practitioner;
- the treatment may be contrary to the wishes of a parent or legal guardian;
- a medical or surgical remedy with a high likelihood of long-term or irreversible life-altering implications is being proposed such as, but not limited to, chemotherapy and organ transplants;
- authorization for organ donation is being sought;
- the case involves questions regarding religious and cultural practices that have an impact on medical or psychiatric care (*e.g.,* children who are Seventh Day Adventists or Christian Scientists);
- a medical, surgical or psychological procedure that is considered non-traditional is being proposed;
- a psychiatric treatment that is exceptionally complex, unusual, controversial, experimental or complicated by ethical or legal issues is being proposed;
- electroconvulsive therapy is being proposed;
- authorization for a child's inclusion in a drug trial or medical study is being sought (this will occur in partnership with the DCF Institutional Review Board);
- life plans or end-of-life decisions are being considered.

**Note:** Consultation with legal staff is required for children who are in DCF custody pursuant to a 96-hour hold or Order of Temporary Custody because it may be necessary to obtain a court order.

**Cross reference**: DCF Policy 26-8-1, "Institutional Review Board."

**MRB Referral Process**

Area Office Social Work or Juvenile Services staff who refer a case to the MRB shall do so utilizing the DCF-785, "Medical Review Board Referral." The form shall include the following information:

- contact information for requestor;
- demographic information for child;
- legal status of child and permanency plan;
- notifications and communications to:
  - child's attorney;
  - child's guardian *ad litem*, if any;
  - biological parents, if parental rights have not been terminated;
  - attorneys for parents, if parental rights have not been terminated;
  - foster parent(s), if placement is intended to be permanent;
  - current placement, if not foster home;
  - primary care provider;
  - medical specialty provider(s); and
  - Area Office Director;

- contact information for primary care provider and medical and mental health specialist(s);
- whether child is currently hospitalized;
- child's current medications;
- child's allergies;
- child's current mental status, including trauma history and impact on current functioning;
- a description of the circumstances that require MRB review; and
- action requested.

The Social Worker shall attach all documentation necessary to fully inform the MRB of the circumstances.

The Social Worker Worker shall work with the RRG Nurse or Nurse Practitioner to make personal contact with the parents or legal guardians and the parents' or legal guardians' attorneys, the foster parents (if appropriate), and the child's attorney and GAL to ensure that they each understand the medical plan, understand the risks and benefits, are in agreement with it, and consent. Documentation of these contacts must be attached to the DCF-785. (**Note:** the attorneys of the parents will confirm their clients' consents, as opposed to consenting themselves.

The DCF-785 shall be signed by the Social Worker and the RRG Nurse or Nurse Practitioner.

**Note:** If any party objects to the medical plan, the Social Worker shall consult with legal staff to determine whether a court order is necessary to proceed.

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**Reviewing the Referral**

Upon receipt of the referral, the chairperson or designee shall review the material for completeness and, with the assistance of the Coordinator, assist the requestor, when necessary, in identifying additional necessary documentation or determining if additional ad hoc committee members will be needed to assist with the review.

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**Response Time**

The chairperson or designee shall begin reviewing and gathering information for all completed referrals within a maximum of ten working days for non-emergency cases.

Emergency cases shall be reviewed immediately.

**Review and Recommendation**

The chairperson may convene a Medical Review Board meeting at his or her discretion. A minimum of four MRB members shall meet to develop a recommendation to the Commissioner. At least one of these MRB members shall be a board-certified pediatrician who is a standing member of the MRB.

In evaluating the referral issues, it may be necessary for the MRB chairperson or Coordinator to contact case-specific attorneys, medical providers, mental health providers, primary physicians, parents, caregivers, foster parents, the child or others to obtain additional information and clarification regarding the child's current status which should include any potential impact of the medical treatment on the child's mental and emotional health.

Whenever possible, recommendations of the Medical Review Board shall be made by consensus. If consensus cannot be reached, the MRB Chairperson or designee shall develop a specific recommendation for review by the Commissioner or designee.

The Medical Review Board Coordinator shall complete the applicable sections of the DCF-786, "Medical Review Board Recommendation: Commissioner's Decision." The chairperson or designee shall sign and date the DCF-786 and forward it to the Commissioner or designee with the MRB's recommendation and supporting documents, including other opinions, if any, expressed by MRB members.

**Decision by the Commissioner**

The decision of the Commissioner or designee shall be recorded on the DCF-786 which shall be returned to the chairperson.

**Distribution and Filing of the Decision**

The chairperson, designee or Coordinator shall provide the Commissioner's decision to the requestor.

A copy of the decision shall be retained by the chairperson. In all cases, a copy of the DCF-786 and accompanying documentation shall be filed in the medical section of the child's Uniform Case Record.

The requesting Social Worker shall inform the Area Office Director, the parents, the parents' and caregivers' attorneys, the child, the child's attorney, any guardians *ad litem* and the foster parents of the decision of the MRB.

If any party objects to the medical plan, the Social Worker or Social Worker shall notify the MRB and consult with legal staff to determine whether a court order is necessary to proceed.

**Follow Up on Referrals**

Follow up on each case referred to the Medical Review Board shall be provided.

Within two weeks of the medical intervention approved by the Commissioner, information from the RRG Nurse or Nurse Practitioner responsible for the case shall be provided to the Medical Review Board Coordinator and chairperson. This information shall include but not be limited to:

- the child's response to the intervention;
- whether the intended goal of the intervention was achieved; and
- the child's current medical and mental condition.

Once a referral is initiated, and especially for end-of-life interventions, the Medical Review Board shall be kept abreast of any changes or new information regarding the case.

The RRG Nurse or Nurse Practitioner shall be responsible for providing follow-up information to the Medical Review Board chairperson as requested.

## Guidelines for the Development of a Life Plan

**Definition of a Life Plan**

A Life Plan:

- is an individualized set of decisions expressing appropriate agreed-upon levels of medical intervention or care limitations for a given child at a given time;
- contains interventions that are individually evaluated for the benefit and burden they present to the child;
- may be considered for children with a life-limiting condition (one for which there is currently no cure available and the likelihood is that the condition will lead to the child dying prematurely);
- evolves over time through shared decision-making;
- is a written, dated document that summarizes the demographics, family members, legal status, history of DCF involvement, medical history, health care providers' recommendations and the results of all discussions by relevant parties that have previously taken place;
- is a document that allows parents or guardians, and perhaps the child, to make decisions and express their wishes in a way that will facilitate decision-making in the event of an emergency or an acute worsening of the child's chronic condition; and
- may be revised at any time but must be reviewed every six months by the Medical Review Board or whenever there is a change to the plan.

A flexible and person-specific Life Plan stating what interventions may be initiated *e.g.,* airway clearance, facial oxygen, trial of bag and mask ventilation, is preferable to a Do Not Resuscitate (DNR) order which is an "all-or-nothing system" and can seem very negative to families.

Similar documents may be referred to as Advance Care Plans, End-of-Life Plans and Wishes documents. Each represents a person-specific plan.

**Life Plan Guiding Principles**

There is a general presumption that all children in the custody of DCF will be fully resuscitated.

There are times, however, when aggressive treatment of children with terminal or degenerative illnesses may be inappropriate and there may be times when a different approach is desirable.

Seriously ill children with life-threatening conditions or facing terminal stages of an illness, and their families, have a variety of needs that require a collaborative and cooperative effort from many disciplines.

The dignity of children and their families and caregivers is respected.

The wishes of children and their families are approached with sensitivity.

The alleviation of pain and suffering is the primary goal.

Individualized and compassionate care is delivered with consideration to cultural and religious beliefs.

**End-of-Life Planning and the Initiation of a Life Plan**

Discussions about end-of-life planning generally begin with the child's primary medical providers.

When the child is committed to DCF, these discussions initially involve the child's Social Worker who will then consult with the Regional Resource Group Nurse.

Decisions about limitations or withdrawal of therapy should take place in a non-crisis situation so that the health care providers and families can discuss the medical realities and the available choices without the emotional burden of an urgent life-threatening exacerbation or impending death.

The discussions and plan development should be led by the child's Social Worker and the child's health care team. They should include the input of biological parents and their attorneys (unless TPR'd), the child's attorney and GAL, foster parents, the Regional DCF team and the DCF Director of Pediatrics.

Biological parents who have not been TPR'd and other relatives should be encouraged to participate in these discussions and their wishes should be respected at every stage of the process.

An ethicist or hospital ethics board should be consulted.

Others familiar with the child may also be invited to participate including the child's specialty health, mental health or developmental providers, teachers, physical and occupational therapists, religious leaders and other significant community providers.

**Referral (DCF-785) to the DCF Medical Review Board to Approve or Review a Life Plan**

The MRB must be involved in reviewing and making recommendations for the approval of a Life Plan.

The referral packet must contain:

- documentation of the child's medical condition and overall prognosis provided by the child's medical provider including specifics about a child's health condition(s) leading to life planning, such as sleep apnea or oxygen de-saturation;
- a comprehensive medical evaluation and opinion about current level of functioning including description of behavior being interpreted as indicating pain or discomfort and successful strategies for relieving this pain or discomfort;
- a description of the child's level of functioning including objective information about the child's life, *e.g.,* whether he or she interacts with peers or adults, whether he or she enjoys certain things of interest, whether he or she recognizes people;
- a brief overview of the child's circumstances including social background, caregivers, why he or she entered care, placement history;
- additional documentation as needed from the child's specialty providers and those individuals who are most familiar with the child such as teachers, physical and occupational therapists and other caregivers;
- a picture or video of the child;
- a brief description of the child's current health circumstances and probable prognosis;
- specific wishes of the family and child; and
- a draft Life Plan outlining medical interventions that are felt to be appropriate as well as treatments or interventions that have been determined to be associated with unnecessary pain and suffering, significant burden on the child or not in his or her best interests.

**Note:** Comfort measures, including nutrition and hydration parameters, must be included in the Life Plan.

**Review of the Referral**

Members of the MRB shall review the referral packet and make a recommendation to the chairperson of the Medical Review Board within 72 hours.

When necessary, the MRB chairperson will convene a meeting or conference call to permit MRB discussion. The MRB chairperson may invite others (such as Area Office staff, care providers, family members) to participate, as requested by the MRB.

**Review of the Referral (continued)**

Urgent reviews of referrals for Life Plan initiation or revision will take place within 24 hours.

MRB members may request additional information from the MRB chairperson or the RRG Nurse or Nurse Practitioners.

A DCF-786, "Commissioner's Decision," will be prepared and signed by the chairperson of the MRB before it is forwarded to the Commissioner or designee for review.

A quorum of MRB members is necessary for a recommendation for approval to be formally made and forwarded to the Commissioner or designee.

**Approval of the Life Plan**

Upon approval by the Commissioner or designee, the DCF-786 will be signed and provided to the MRB chairperson.

The Area Office will be informed of the Commissioner's decision and provided a copy of the DCF-786.

The Social Worker collaborating with the RRG nurse is responsible for communicating the Commissioner's decision to medical staff caring for the child.

If approval of the Life Plan is denied, the Commissioner or designee will document the denial and rationale on the DCF-786 and communicate that to the MRB chairperson.

**Routine Renewal of Life Plan**

All Life Plans shall be reviewed every six months by the Medical Review Board.

A referral (DCF-785) should be made for review and renewal of the Life Plan. The process as described above should be followed.

Changes in the child's condition and current clinical status must be documented by the medical provider caring for the child.

The providers shall communicate any desire to revise or modify the Life Plan in any way.

Comfort measures must always be addressed.

The child's biological parents and their attorneys (if not TPR'd) and the foster parents must be consulted by the Social Worker regarding their wishes to continue or modify the Life Plan.

**Discontinuation of Life Plan**

Under certain conditions, such as remission of symptoms or the changed wishes of the parent or child, discontinuation of the Life Plan may be considered.

**Do Not Resuscitate (DNR)**

When a child is terminally ill and prolongation of life would only cause further pain and suffering, the legal guardian may agree to allow the physician to write a medical order that states "Do Not Resuscitate" (DNR).

This order must have clear details that specify the level of intensive intervention permitted.

The American Heart Association standards require that a DNR order is:

- in writing;
- signed by the patient's attending physician; and
- based on documentation that the patient is irreparably, irreversibly and terminally ill.

A DNR order might be written for:

- a child receiving palliative or hospice care;
- a terminally ill child on a ventilator in the ICU;
- a child determined to be brain dead; or
- a terminally ill child in a chronic care facility.

Comfort and pain alleviation, as well as nutrition and hydration, shall be provided in every situation.

DNR orders are clinically and ethically appropriate when the burdens of resuscitation exceed the expected benefit.

A DNR order precludes resuscitative efforts being undertaken in the event of cardiopulmonary arrest and does not have implications regarding the use of other therapeutic interventions that may be appropriate for the patient. When anticipated, decisions regarding these other interventions should already be addressed in the Life Plan.

**Required Reconsideration of Life Plan or DNR Orders for Operative Procedures**

Life Plans and DNR orders should be reevaluated for a child who requires an operative procedure. This process is called "required reconsideration" and should be incorporated into the informed consent process for surgery and anesthesia.

If DNR orders are suspended during surgery and anesthesia, it is important to define the duration of suspension.

The American Academy of Pediatrics recommends that suspension of DNR orders should continue until the post-anesthetic visit, until the patient has been weaned from mechanical ventilation or until the primary physician and the family agree to reinstate the DNR order.

**Additional Definitions**

**"End of life"** although there is no exact definition, usually contains the following components: (1) the presence of a chronic disease or symptoms or functional impairments that persist but may also fluctuate; and
(2) the symptoms or impairments resulting from the underlying irreversible disease require formal (paid, professional) or informal (unpaid) care and can lead to death.

"**End-of-life care"** means medical care not only of patients in the final hours or days of their lives but, more broadly, medical care of all those with a terminal illness or a terminal condition that has become advanced, progressive and incurable.

**"Do not resuscitate" or "DNR"** means a medical order stating that resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. It tells medical professionals not to perform CPR. DNR orders may be written for patients in a hospital or nursing home or for patients at home. Hospital DNR orders tell the medical staff not to revive the patient if cardiac arrest occurs. If the patient is in a nursing home or at home, a DNR order tells the staff and emergency medical personnel not to perform emergency resuscitation and not to transfer the patient to a hospital for CPR.

**"Cardiopulmonary resuscitation" or "CPR)"** means the medical procedures used to restart a patient's heart and breathing. CPR may involve simple efforts such as mouth-to-mouth resuscitation and external chest compression. Advanced CPR may involve electric shock, insertion of a tube to open the patient's airway, injection of medication into the heart and, in extreme cases, open-chest heart massage.

**"Best interests standard"** serves as the basis for decisions for patients who have never achieved decision-making capacity, including infants and young children. Capacity may be determined by the attending physician but sometimes requires formal developmental, psychiatric or other consultation to help determine the patient's abilities and the appropriateness of the child's participation in making decisions.

## DCF Health Standards and Practice Committee

**Purpose**

The Health Standards and Practice Committee shall advise and assist DCF in the development of the statewide plan for the oversight and coordination of health care services for children in foster care.

**Duties and Responsibilities**

The Health Standards and Practice Committee shall, as a whole or through the use of sub-committees:

- develop or review and monitor the implementation of all state-wide and Region-specific plans affecting medical and mental health programs and services;
- consult on the development of DCF's Health Oversight and Coordination Plan as required by Fostering Connections to Success and Increasing Adoptions Act of 2008 (PL 110-351; section 205);
- review, recommend and monitor implementation of new policies, procedures and programs for delivery of primary medical or mental health services to children;
- coordinate the work of the Regional Office medical staff with medical or mental health providers in the community;
- review, recommend and monitor implementation of new policies and procedures for collection and use of information regarding the medical or mental health needs of, and services provided to, children;
- adopt standards for use by DCF Quality Assurance to judge the adequacy and appropriateness of medical or mental health care services delivered to children;
- advise the Director of DCF's Academy for Family and Workforce Knowledge and Development on the development of trainings for DCF staff, foster parents, caregivers and prospective adoptive parents regarding recognizing and meeting children's medical and mental health needs;
- assess the available community services for children; and
- assess the use of the Health Passport and other health documentation including the LINK Medical Alert, the Health Passport Health Summary (DCF-741HS) and the Report of Health Visit (DCF-742).

**Outside Participation**

In addition to DCF staff, consumers, consultants and medical professionals from the community and representatives of other state agencies shall be invited to participate in the Health Standards and Practice Committee so as to:

- act as liaisons with other state agencies concerning children in the custody of DCF; and
- develop written policies and procedures to improve children's access to needed services and programs provided by those agencies.

**Meetings** The Committee shall meet at least quarterly for the first year of its existence. Thereafter, the frequency of meetings shall be evaluated relative to the Committee's operations in fulfilling its responsibilities.

**Membership** The Health Standards and Practice Committee shall be comprised of:

- the DCF Chief of Pediatrics;
- the DCF Chief of Psychiatry;
- one Regional Administrator or designee;
- a representative of the Connecticut Chapter of the American Academy of Pediatrics;
- a representative of the Connecticut Council of Child and Adolescent Psychiatry;
- a representative of DCF's Nursing Community of Practice (COP);
- the Commissioner of the Department of Social Services, or designee;
- the Commissioner of the Department of Developmental Services or designee;
- the Commissioner of the Department of Public Health or designee;
- the Commissioner of the Department of Mental Health and Addiction Services, or designee;
- a representative from the Connecticut Behavioral Health Partnership;
- a foster parent, adoptive parent or caregiver;
- a biological parent;
- a Connecticut State Board of Education nurse consultant;
- a pediatrician with expertise in child abuse and neglect; and
- a pediatrician with expertise in Pediatric Medical Home or Patient-Centered Medical Home (PCMH), which is a team based health care delivery model led by a physician that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.

## Standards and Practice for Special Populations

## Children with Complex Medical Needs

**Purpose**

Children with complex medical needs are particularly vulnerable and therefore require medical oversight and monitoring consistent with their level of complexity and risk.

This Practice Guide provides guidelines for the care of these children and outlines specific components and principles.

**Components**

For all children with complex medical needs in DCF care, there shall be oversight and monitoring by the DCF Social Worker, a Regional Resource Group (RRG) Nurse and, as needed, DCF's Chief of Pediatrics and his or her staff.

Oversight activities shall include, but not be limited to:

- direct contact, as needed or when requested, with a child's primary health care provider, medical specialist or medical home to discuss the medical plan for care of the child;
- oversight and monitoring of health care, including the provision and receipt of recommended services and interventions consistent with standards outlined by American Academy of Pediatrics (AAP), and Early Periodic Screening Detection and Treatment (EPSDT);
- monitoring of mental health including continual assessment for the presence of traumatic stress and an action plan developed to address the mental health needs of the child since complex medical conditions are a source of traumatic stress for children and youth;*
- routine placement visits with the assigned Social Worker or other Area Office staff to assess the child's medical and mental health status and quality of care;
- documentation in LINK of the child's medical status, including specifics of care, services received and results of any site visits or medical planning meetings; and
- involvement and assistance with permanency planning.

The frequency of visits, contact with providers and other activities shall be determined on a case-by-case basis in consideration of the level of complexity and classification as specified below.

A review of the medical care of children involved with DCF who are being followed by each RRG nurse shall be performed by DCF's Chief of Pediatrics and his or her staff as needed or as requested by the RRG Nurse or other DCF staff.

*Reference: ”Pediatric Medical Traumatic Stress Toolkit for Healthcare Providers,” (2011), http://www.nctsn.org/trauma-types/pediatric-medical-traumatic-stress-toolkit-for-health-care-providers.

**Definitions**

**"Child with complex medical needs"** means a child who has one or more of the following:

- a diagnosable, enduring, life-threatening medical condition;
- a medical condition that has resulted in substantial physical impairment;
- a medically-caused impediment to the performance of daily age-appropriate activities at home, school or in the community; or
- a need for medically-prescribed services as identified on the DCF-2101, "Certification of a Child with Complex Medical Needs."

**"Child-specific medical training" or "CSMT)"** means a 1:1 training given to a caregiver, prior to or on the day of placement, about the medical and associated care needs of a child with complex medical needs. Training should be given by a health care professional (physician or nurse outside of DCF) familiar with the child's care. Training will include:

- medical needs:
  - the child's baseline medical status and parameters for medical intervention;
  - recognition of the signs and symptoms that require medical and mental health interventions; and
  - review of medication including any psychotropic medications and the reasons for their use;

- associated care needs:
  - how to safely transfer, feed, bathe, toilet and conduct other daily routines for the child;
  - techniques on how to perform exercises and or therapies; and
  - how to use adaptive equipment (*e.g.,* donning braces);

- traumatic effects of complex medical conditions on children:
  - how to respond to a child's reactions to trauma; and
  - how to provide medical treatment in the least-traumatizing way.

**Classification of Children with Complex Medical Needs**

Children with complex medical needs shall be classified into one of four classifications:

1. **Potential Condition-Related Risk** means a child who has a chronic health condition which is under good control but requires an educated caregiver. Chronic diseases in this classification include but are not limited to mild or moderate persistent asthma, cancer in remission until the child is medically cleared by the medical provider, chronic infections such as Hepatitis C and latent tuberculosis which require monitoring but no treatment, well-identified allergies which require Epi-pen use, or a newborn with perinatal substance exposure requiring medication upon discharge.

2. **Medically at Risk** means a premature infant (born at less than 32 weeks gestation) or a child who has a chronic health condition which may periodically become life-threatening such as well-controlled insulin-dependent diabetes, a well-controlled seizure disorder requiring medication, moderate-to-severe asthma that has not resulted in a pediatric intensive care (PICU) or acute hospitalization in the last six months or a chronic infection such as hepatitis C or latent tuberculosis for which the child is receiving treatment. (**Note:** Conditions resulting in repeated hospitalizations shall be classified as Level 3.)

3. **Intensive Medical Needs** means a child with a chronic condition that is not well-controlled or which requires daily or regular intensive medical follow-up or treatment, including severe forms of chronic disease such as poorly-controlled insulin-dependent diabetes, diabetes that requires the use of an insulin pump, a poorly controlled seizure disorder, hemophilia, an immune disorder, or severe persistent asthma which requires intensive and ongoing medical follow-up or has required an acute hospitalization or PICU admission in the past six months.

4. **Technology-Dependent or Medically-Dependent:**
   **Technology-Dependent** means a child who requires a mechanical device or special technological intervention to maintain or sustain life. Children in this classification require routine or periodic assistance from trained and licensed nursing personnel and the availability of professional skilled nursing personnel for assessment of the child's medical status. Examples of children who are technology-dependent are those who require substantial assistance with activities of daily living, those who are unable to ambulate independently due to cerebral palsy or developmental disabilities, and those who may be temporarily unable to ambulate independently due to an injury or surgery, but who are expected to remain in this status only temporarily.

   **----- OR -----**

   **Medically-Dependent** means a child whose medical status requires specially-trained personnel immediately available to attend to the child, for whom a skilled nursing assessment may be needed as frequently as every two hours or for whom round-the-clock nursing care is required. Children who are medically-dependent may be able to live outside of a medical care facility, but are dependent upon a high level of care and assessment in order to sustain life, such as children with tracheostomies or on ventilators.

**Process to Establish a Child as Having Complex Medical Needs**

When a DCF Social Worker obtains information from any source which suggests that a child in DCF care may have complex medical needs, the Social Worker shall review the available documentation and contact the child's primary health care provider or medical home for additional information.

The Social Worker shall:

- consult with the Regional Resource Group (RRG) Nurse to make a preliminary determination as to whether or not the child is medically complex and, if so, into which classification the child falls;
- complete Section I of the DCF-2101, "Certification of a Child as Having Complex Medical Needs;"
- forward the DCF-2101 to the child's primary health care provider for identification and certification of the child's specific medical needs;
- upon receipt of the signed DCF-2101 from the provider, submit the form to the RRG Nurse, Social Work Supervisor and Program Manager for review and signatures;
- document the child's complex medical needs status in the LINK medical profile, and document any consults and the completion of the DCF-2101 in the LINK medical narrative;
- notify the RRG Nurse of all hospital discharge planning meetings;
- file the original DCF-2101 in the child's case record;
- send a copy of DCF-2101 to the RRG Nurse; and
- notify the DCF Office of Children and Youth in Placement of the child's medically complex designation.

**Note:** If the RRG Nurse and primary health provider do not agree on the child's classification, the Nurse shall review the DCF-2101 with the DCF Chief of Pediatrics or designee to determine the appropriate classification.

**Ongoing Case Management and Visitation Standards for RRG Nurses**

All children with a medically complex classification shall have an initial visit by the assigned Social Worker and the RRG Nurse within two weeks of the initial placement date or at the time of the completion of the initial DCF-2101.

Thereafter, the RRG Nurse shall, at a minimum:

- **for all Classifications,** review the DCF-2101 every six months and if there are questions or concerns, call the foster parent or visit the child and review the child's trauma screening results for an update on how the child is emotionally managing his or her medical condition;

- **for Classification 1**, conduct an initial visit as a follow-up to completion of the initial DCF-2101; make additional visits or phone calls if clinically necessary based on a review of the DCF-2101 or if a specific concern or question arises; conduct annual visits with the child if deemed necessary;

**Ongoing Case Management and Visitation Standards for RRG Nurses (continued)**

- **for Classification 2**, visit annually with additional visits or phone calls if the RRG Nurse deems it clinically necessary based on a review of the DCF-2101 or if a specific concern or question arises;
- **for Classifications 3 and 4** – visit every six months with additional visits or phone calls if the RRG Nurse deems it clinically necessary based on a review of the DCF-2101 or if a specific concern or question arises.

The RRG Nurse visitation standard shall be met regardless of the location of the child's placement or the type of placement unless a modification is approved by the Regional Program Director for Clinical Services following consultation with the DCF Chief of Pediatrics or designee. All modifications shall be documented by the Regional Program Director for Clinical Services in the LINK narrative.

For foster home placements, the first visit to the foster home shall also include the FASU Social Worker assigned to the foster family whenever possible.

**Re-certification of a Child with Complex Medical Needs**

The child's medical status must be reviewed and re-certified by the child's primary health care provider every six months.

To obtain re-certification, the Social Worker shall follow the same procedures as for initial certification:

- submit a new DCF-2101 for signatures;
- request that the child's primary health care provider complete a new DCF-2101 based on the child's medical status; and
- once returned by the provider, review the DCF-2101 with the Social Work Supervisor and the RRG Nurse.

**Removing a Child from Medically Complex Status**

To remove a child from medically complex status, the Social Worker must submit the DCF-2101 to the child's primary health care provider for verification that the child currently does not require any of the care listed on the DCF-2101.

If it is determined that the child should no longer be classified as medically complex, the RRG Nurse shall send a request to the Central Office database manager to change the child's status to "inactive."

The Social Worker shall document the change to the child's status in LINK and inform the foster parent.

The Social Worker shall inform the DCF Office of Children and Youth in Placement of the change in child's status.

**If the Child is Receiving an Adoption or Guardianship Subsidy**

If the child is receiving an adoption or guardianship subsidy, recertification shall involve the following:

- annually, the DCF Subsidy Unit shall send a DCF-2131, "Release of Information," to the adoptive parent or relative guardian;
- the Subsidy Unit staff shall send the completed DCF-2131 and the DCF-2101 to the medical provider for completion; and
- if the child's provider determines that the child should no longer be classified as medically complex, the family shall be contacted by the Subsidy Unit and sent a DCF-800, "Notice of Proposed Denial, Suspension, Reduction or Discontinuance of DCF Benefits."

**Note:** The DCF-2131 allows the Subsidy Unit to contact the provider regarding the child's current medical condition.

**Ongoing Monitoring, Tracking and Quality Assurance**

The RRG Nurse and Social Worker shall enter any medical information gathered during conversations or at visits, including provider visits, into LINK and update the medical summary as appropriate. This shall include information from the DCF-742, "Report of Health Care Visit," and any other medical reports.

The RRG Nurse shall maintain a log of all children with complex medical needs who are served by his or her Area Office.

At a minimum, these databases shall include:

- the Area Office location;
- the child's
  - name,
  - gender,
  - date of birth,
  - legal status,
  - LINK number,
  - person ID,
  - diagnosis/es,
  - medically complex classification,
  - type of placement, and
  - location and name of placement.

The RRG Nurse shall also provide, on a quarterly basis, a workbook with updates on children with complex medical needs to the Central Office medically complex database manager.

**Administrative Oversight**

The Regional Administrator shall assign a manager who shall have administrative oversight for medically complex cases in that Region. This manager shall be the point person for the DCF Chief of Pediatrics or designee regardless of the manager assigned to the direct supervision of the child's case.

The administrative oversight shall ensure that, whenever possible, new cases with children who are designated as Classifications 2, 3 and 4 are assigned to Social Workers specially designated for working with children with complex medical needs.

Social Workers specially designated for working with children with complex medical needs shall receive training regarding issues unique to this population, including training on the traumatic effects of complex medical conditions on children, from specially-trained trauma trainers and medically complex program staff responsible for children with complex medical needs.

Children who are designated as Classifications 3 and 4 after initial case assignment shall be re-assigned to Social Workers specially designated for working with children with complex medical needs, unless it is not in the child's best interests due to the stability of the relationship with the current Social Worker or for the near-term accomplishment of permanency.

**Role of the RRG Nurse or Nurse Practitioner**

The RRG Nurse or Nurse Practitioner shall:

- review all DCF-2101s, "Certification of a Child with Complex Medical Needs," for appropriateness of medically complex certification and compliance with policy;
- assist the Social Worker in the completion of the DCF-2102, "Placement Plan for a Child with Complex Medical Needs" and review the DCF-2102 for accuracy and completeness of medical information and compliance with policy;
- review all medical documentation including the LINK Medical Alert and the Health Passport Health Summary (DCF-741HS) for accuracy and completeness;
- participate in hospital discharge planning meetings for medically complex children;
- participate with the Office of Children and Youth in Placement, the Social Worker, the Social Work Supervisor, the foster parent and others in providing medical consultation during the placement of children with complex medical needs;
- maintain a log or database of all children with complex medical needs known to the RRG and update it regularly with current medical information;
- provide the Central Office database manager with an updated electronic workbook on a quarterly basis;
- review results of any medical information provided by the Social Worker about a child with complex medical needs and assist in ensuring medical follow-up as needed; and
- assist the Social Worker in ensuring that consults, assessments, treatment services and recommendations are documented in the LINK narrative.

**Administrative Case Review (ACR): Preparation**

Sixty days prior to the proposed ACR date for a child, the Social Worker and Social Work Supervisor will receive an email notification alerting them that an ACR will be scheduled for a specific case and informing them that they must identify participants to be included in the ACR including the RRG Nurse or Nurse Practitioner if the case involves a child with complex medical needs. The Social Worker shall send an invitation email to the RRG Nurse or Nurse Practitioner no later than 21 days prior to the ACR.

The RRG Nurse or Nurse Practitioner should also receive a copy of the updated trauma screen for each child, if one has been completed.

The RRG Nurse or Nurse Practitioner will:

- review the child's history and develop a summary highlighting on-going or unmet needs which need to be addressed in the ACR, including needs related to any trauma reactions the child may be experiencing related to his or her medical condition;
- highlight unmet needs and outstanding issues requiring follow up by the Social Worker, including the need for EPSDT or dental preventative services; the need for medical follow up with the PCP or a specialist; the need for psychotropic medication monitoring; the need for trauma-specific screening, assessment and treatment; and recommendations for permanency planning; and
- email the summary to the Social Worker, Social Work Supervisor and Program Director of Clinical Services at least two weeks prior to the ACR. **(Note:** In preparation for a child's first ACR, the MDE report will be sent along with the summary.)

Any questions about the summary should be reviewed with the RRG Nurse or Nurse Practitioner prior to the ACR.

Medical icons and the "Health Passport Health Summary" (DCF-741HS) and LINK Medical Profile will be updated by the Social Worker.

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**Administrative Case Review: Process**

The most recent DCF-2101 shall be reviewed at each Administrative Case Review (ACR).

The RRG Nurse shall attend the ACR for all children with complex medical needs in Classifications 3 and 4.

The RRG Nurse will also attend the ACR when:

- the RRG Nurse has provided assessment services to the child or family within the six months prior to the ACR; or
- upon reviewing the ACR list, the RRG Nurse identifies a child with significant unmet needs, including needs related to a child's reaction(s) to the traumatic effects of complex medical conditions.

The medical icon and the LINK Medical Alert and "Health Passport Health Summary" (DCF-741HS) shall be updated following the ACR and include plans as developed in the Comprehensive Health Plan portion of the Case Plan.

**Cross reference:** Administrative Case Review Policies 36-11-1 and 36-11-2.

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**Placing a Child with Complex Medical Needs**

When a child with complex medical needs is placed with a foster family, the match shall be made to a foster home prepared to care for children with complex medical needs, which includes having an understanding of the traumatic nature of complex medical conditions and how to respond to a child who has experienced trauma.

**Matching of a Child with Complex Medical Needs**

A consultation with the Regional Resource Group Nurse shall be required before placing a child with complex medical needs and whenever a child with complex medical needs is being considered for placement into a home that has other medically-involved children. Consideration shall be given to the child's needs, the resources of the home and the demands on the time of the foster parent.

**Qualification of Foster Parents**

Children with complex medical needs in **Classification 1** shall be placed with foster parents who:

- hold a current foster care license and are in good standing with DCF;
- have the desire to and interest in serving and caring for children with complex medical needs;
- can identify a back-up caregiver who meets the qualifications set forth in this Practice Guide (see "Qualifications for Back-up Caregiver"); and
- have a basic understanding of the potentially traumatic effects the child's medical condition could have on the child and have the skills to address the trauma-related needs of the child.

The foster parents shall complete:

- the "Medically Complex Pediatric Health" curriculum (Module 11) or the Pride class "Fostering Health for Children in Foster Care;"
- age-appropriate CPR training;
- child-specific medical training; and
- training on child trauma and child traumatic stress.

Children with complex medical needs in **Classifications 2-4** shall be placed with foster parents who:

- hold a current foster care license and are in good standing with DCF;
- have the desire to and interest in serving and caring for children with complex medical needs;
- complete the certificate training, "Medically Complex Certification Course," for the care of children with complex medical needs;
- complete age-appropriate CPR training;
- can identify a back-up caregiver who can meet the qualifications specified in the section below;
- complete child-specific medical training prior to a child's placement in the home; and
- have a basic understanding of the potentially traumatic effects the child's medical condition could have on the child and have the skills to address the trauma-related needs of the child.

**Qualifications for Back-Up Caregiver**

All persons approved by DCF to care for a child with complex medical needs shall be supported by a back-up caregiver who has received the same level of training.

If there are two licensed foster parents in the home who have been certified to care for a child with complex medical needs, one parent will be considered the primary caregiver and the other will be the back-up caregiver.

If there is only one licensed foster parent in the home who has been certified to provide such care (the primary caregiver), a back-up caregiver must be available to assist the primary caregiver as needed.

The back-up caregiver:

- does not have to be a licensed foster parent, but must meet the same requirements as the foster parent for certification for the care of children with complex medical needs;
- must maintain current CPR certification;
- may live in the foster parent's home;
- if not a licensed foster parent, must provide care to the child in the licensed foster home; and
- must take all of the same training as the foster parent and have completed child-specific medical training and the "Medically Complex Certification" course.

If the proposed back-up caregiver is not a licensed foster parent, the FASU Social Worker must obtain the following information about the person, which is required for applicants for foster care licensure:

- child protective services history;
- three references;
- DCF-357, "Physician's Report of a Physical Examination;"
- DCF-2111, "Disciplinary Statement;" and
- DCF-2112, "Confidentiality Statement."

The FASU Social Worker shall determine if the proposed back-up caregiver is an appropriate candidate for certification training and, if so, shall:

- notify the Central Office Medically Complex Unit Nurses, who will arrange for the certification training; and
- file the proposed back-up caregiver's documentation in the licensed foster parent's record.

**Request for a Placement**

Prior to requesting a placement, or immediately following the placement, the child's Social Worker must have obtained the DCF-2101, "Certification of a Child with Complex Medical Needs," signed by the child's primary health care provider.

The child's Social Worker shall also consult with the RRG Nurse and complete the DCF 2102, "Placement Plan for a Child with Complex Medical Needs," to identify medical needs, equipment, medication and other specific needs, including mental health needs related to trauma. The completed DCF-2102 should be given to the FASU matcher.

**If Certified Homes are not Available**

In the event that an appropriate home certified as medically complex is not available, and a non-certified resource is identified, then the FASU Program Manager, after consultation with the RRG Nurse, shall follow the principles of matching to:

- ensure that the foster family is willing to become certified as medically complex (not required for children in Classification 1);
- ensure that the foster family will participate in child-specific training and receive age-appropriate cardiopulmonary resuscitation (CPR) certification through an accredited organization;
- ensure that the foster family will participate in trauma-specific training to understand how complex medical conditions can be potentially traumatic for a child and to develop the skills necessary to respond to the child's mental health needs related to trauma;
- ensure that the foster parent has a qualified back-up caregiver willing to receive the same training; and
- notify the Central Office Medically Complex Program Nurses that the parents require medically complex certification.

The non-certified resource must complete child-specific medical and trauma-specific training prior to the placement taking effect, in accordance with the Post-Licensing Certificate Training requirements outlined in this Practice Guide.

**Area Office Staff**

Upon receipt of the DCF-469, "Agreement for Placement," a copy of the LINK Medical Alert or the DCF-741HS, "Health Passport Health Summary," and, if indicated, the DCF-2102, "Discharge Plan for a Child with Complex Medical Needs," the FASU Supervisor shall coordinate with the matcher and the child's Social Worker and Social Worker Supervisor to facilitate all aspects of placing a child with complex medical needs.

The child's Social Work Supervisor shall:

- consult with the child's Social Worker, FASU support worker, FASU Supervisor, and RRG Nurse to identify the home characteristics needed for the placement and the child-specific medical training required for the caregiver; and
- if the RRG Nurse is not available, make efforts to contact the covering nurse, the Medically Complex Program Nurses, or the physician on call through the Careline to consult on the case.

**Area Office Staff (continued)**

The FASU Supervisor shall:

- ensure that the most appropriate home for the child has been identified;
- ensure that the matcher makes face-to-face or telephone contact with the Social Worker who is making the placement request to discuss the child's placement needs and to document other pertinent information on the DCF-469; and
- ensure that the Social Work Supervisor for the child is kept current and involved regarding any developments with the placement resource.

The FASU matcher shall:

- search for all available and appropriate foster homes that are certified to care for children with complex medical needs based on all available information (children in Classification 1 do not need to be in Medically Complex Certified homes); and
- ensure that the initial telephone contact with the foster parent has been made and as much information as possible has been provided including any special needs, details related to the child's trauma-specific reaction to the medical condition and any interventions that are being used to help address those reactions, and the circumstances of placement.

**Use of Private Agency Homes**

DCF may place children with complex medical needs in foster homes approved by licensed, private child-placing agencies if those homes meet the criteria for caring for these children.

**Placement Plan**

The child's Social Worker shall develop and implement a placement plan, to be documented on the DCF-2102, "Discharge Plan for a Child With Complex Medical Needs," in consultation with the RRG Nurse.

**Note**: Placement plans shall include those for children who are being discharged from a hospital setting.

The child's Social Worker shall ensure that the DCF-2102 is completed and included with the Health Passport.

The DCF-2102 shall specify the necessary equipment, adaptations to the home and vehicle, in-home services and providers, and DCF support services including trauma-specific services and educational planning appropriate for the child.

The DCF-2102 shall be signed by the primary health care provider, reviewed by the RRG Nurse and approved by the Program Manager.

When the child is being discharged from a hospital, the discharge shall be conducted in accordance with the DCF Guidelines for Hospital Discharge located on the DCF Intranet.

**During Placement**

The child's Social Worker shall:

- ensure that the foster parent is trained to meet all aspects of the individual child's medical needs (child-specific medical training) and mental health needs (trauma-specific training) prior to the placement of the child in a foster or respite care home; and
- ensure that the provider is given the placement portfolio and completed forms, which include the DCF-469, a copy of the LINK Medical Alert or "Health Passport Health Summary" (DCF-741HS), and the DCF-2102.

**After Placement**

After placement has been completed, the child's Social Worker shall be responsible for documenting the child-specific medical training in the LINK narrative. Documentation shall cover the following topics:

- name and qualification of licensed health care professional;
- components of the child-specific training;
- components of the trauma-specific training;
- location of trainings;
- lengths of training given to the foster parent and back-up caregiver during the child-specific training; and
- confirmation through the trainers that the foster parent and back-up caregiver have demonstrated a good understanding of the child's needs.

Ongoing documentation is required if any additional training has been provided to the parents after the placement, during doctor visits, home care visits, or any other training sessions, using the same criteria as above.

The child's Social Worker and the FASU Support Social Worker shall make additional home visits to the home of a newly-placed medically complex child to:

- follow up on changes in status;
- offer additional supports as needed; and
- collect the DCF-742, "Report of Health Care Visit."

The information shall be documented in the medical section of LINK.

**Placement from a Hospital**

If the child is being discharged from a hospital, procedures for the discharge shall be conducted in accordance with the DCF Guidelines for Hospital Discharge of Children with Complex Medical Needs.

**Social Worker Responsibilities**

The child's DCF Social Worker shall:

- make a referral to the RRG Nurse or Nurse Practitioner;
- ensure the DCF-2101, "Certification of a Child's Complex Medical Needs," is completed and signed by the child's health care provider (facilitated by the RRG Nurse or Nurse Practitioner if necessary);

**Social worker Responsibilities (continued)**

- work with the RRG Nurse or Nurse Practitioner and the hospital to ensure that an interdisciplinary discharge planning meeting is arranged that includes the child's medical team and other appropriate participants such as the parents, a managed care representative, a home care nurse, etc.;
- consult with the Health Advocate;
- ensure that coverage of prescriptions, durable medical equipment and home nursing care has been approved prior to discharge;
- ensure that the child's primary care provider is informed of the hospital discharge;
- for a new placement, ensure that primary health care provider has been chosen and has agreed to care for the child after discharge;
- assess the potential foster home for environmental hazards (**see** "Examples of Potential Environmental Factors" in DCF Guidelines for Hospital Discharge of Children with Complex Medical Needs);
- confirm with the hospital staff that the foster parents have been trained in all caregiving tasks, including emergency tasks, and have demonstrated competency in performing these tasks;
- confirm with the hospital staff or home care nurse that the necessary equipment and medications are available in the home;
- ensure referrals to appropriate clinics and physicians for follow-up care are scheduled;
- ensure emergency plans are in place to address power outages for those children who require electrical power;
- ensure that local emergency medical services are informed of the child's presence in the home; and
- ensure that emergency plans for fire, unpassable roads, etc., have been established.

**The Day of Discharge**

Any discharge of a child in DCF custody to a foster placement should not take place on a weekend or during "off" hours unless all discharge criteria identified above have been met.

Discharges of children who have been hospitalized for an extended period of time and who will need home nursing care or durable medical equipment should not occur on Fridays, Saturdays or Sundays nor during "off" hours unless otherwise planned and approved by appropriate DCF administrative staff.

If DCF is the child's legal guardian, the Social Worker or other representative shall go to the hospital to sign the required discharge forms.

As appropriate, the foster parent(s) shall go to the hospital to receive the child being discharged into his or her care.

A contact at the hospital shall be identified to the foster parent(s) to answer questions and assist with problem resolution during the immediate post-discharge period.

The Social Worker shall provide the foster parents with a written summary of the child's problems and history (*i.e.,* the DCF 2101 or DSS Interagency Referral Form (W10): www.catalog.state.ct.us/dss/eduplicating/viewForm.asp).

**Post-Licensing Medically Complex Training and Certification**

DCF Central Office Medically Complex Unit Nurses shall provide post-licensing training and certification for families who wish to care for children with complex medical needs.

The Division of Health and Wellness and the Office of Children and Youth in Placement shall coordinate the certification program.

**Requirements for Certification**

To become certified as a medically complex caregiver for children in Classifications 2, 3 and 4, the following requirements must be met unless a waiver has been granted (as specified below):

- complete a minimum of 20 hours of medically complex training consisting of:
  - Medically Complex Certification Course (MCCC) (7 lectures);
  - age-appropriate cardiopulmonary resuscitation (CPR); and
  - training on trauma and traumatic stress.

| Class | Trainer(s) | Content |
|---|---|---|
| MCCC Lecture 1<br><br>Introduction to the Care of the Child with Medically Complex Needs | Central Office Medically Complex Program Nurses<br><br>RRG Nurse or Nurse Practitioner<br><br>OChYP Staff | Introduction to children with complex medical needs<br><br>Responsibilities of foster parents and DCF |
| MCCC Lectures 2-7<br><br>These lectures may include the following topics as well as other topics as needed:<br><br>• respiratory<br>• orthopedic<br>• neurological<br>• gastrointestinal | Health Care Providers<br><br>Doctors<br><br>Nurses or Nurse Practitioners<br><br>Physical Therapists<br><br>Occupational Therapists | Each class will cover topics such as:<br><br>• basic anatomy and physiology;<br>• description of complex medical conditions;<br>• signs and symptoms of condition-specific problems;<br>• usual course of treatment;<br>• home care and parenting needs;<br>• frequently prescribed medications and administration;<br>• decision making: when to call the physician or home care nurse;<br>• infection control |
| Experienced Foster Parent Lectures | Foster parents who are experienced in the care of children with complex medical needs | Integration of the child into the family, including topics such as:<br><br>• use of community resources;<br>• time management and organizational skills;<br>• communication with DCF and medical providers; and<br>• normalizing the child's life |
| CPR | Accredited Agency (outside DCF) | Infant/child CPR and age-appropriate CPR |

**Documentation of Certification**

The Central Office Clinical Nurse Coordinator shall:

- make the final determination that the foster parent and back-up caregiver have successfully completed all requirements for certification; and
- provide the FASU Program Manager with the names of those foster parents and back-up caregivers who have been certified.

The FASU Program Manager shall ensure that the foster parent's certification status is entered in LINK. The back-up caregiver's documentation shall be filed in the foster parent's licensing record.

**Compensation**

DCF foster parents, back-up caregivers and respite providers shall be paid a stipend of $250.00 per person upon completion of the certificate training requirements.

**Note:** Transportation and child care expenses are incorporated into the stipend rate.

**Re-certification Requirements for Foster Parents**

In order for foster parents to continue to be certified to provide care for children with complex medical needs, they shall complete the requirements listed below within the stated time frames.

These re-certification requirements are in addition to the mandatory post-licensing requirements to maintain foster care licensure.

| Time Frame | Re-certification Requirement |
|---|---|
| **Ongoing** | Maintain current CPR certification |
| **Biennially** | Continuing education related to the needs of this population of children and their caregivers. |
| **Ongoing** | Demonstrate consistent, competent ability to care for children with complex medical needs, including needs related to trauma, as determined by medical and trauma treatment professionals. |

**Documentation and Review of Requirements for Re-certification**

All requirements for re-certification shall be documented in the foster parent's record and reviewed at the time of biennial re-licensure.

| Person | Action |
|---|---|
| Central Office Medically Complex Unit | Notify the FASU Program Manager when a foster parent has completed CPR re-certification and other related trainings, including training on trauma and child traumatic stress. |
| FASU Program Manager | Ensure that the foster parent's LINK training record is updated when the above requirements are completed. |
| FASU Social Worker | At the time of biennial re-licensure:<br>• review the entries in the foster parent's training record;<br>• consult with the RRG Nurse regarding the foster parent's demonstrated competency in caring for the child in the home;<br>• discuss any recommended or required training needs with the foster parent;<br>• note in the foster parent's record whether or not the requirements have been met for continuing certification; and<br>• notify the Central Office Clinical Nurse Coordinator if requirements have not been met at the time of re-licensure, or annually, depending on the CPR expiration date. |

**Reimbursement for Re-certification**

DCF will:

- pay for the CPR training for foster parents; and
- reimburse the foster parent for transportation and child care expenses incurred while attending required training for re-certification.

**Re-certification Requirements for Back-Up Caregiver**

The back-up caregiver must maintain current CPR certification.

Documentation of completed trainings must be filed in the foster parent's record.

**When Not in Compliance**

If the foster parent or back-up caregiver does not meet the above requirements, the Central Office Medically Complex Unit Nurses shall consult with the RRG Nurse, the child's Social Worker and Social Work Supervisor, the FASU Program Manager and others as appropriate regarding action to be taken at the time of re-licensure, or annually, depending on CPR expiration date.

**Waiver of Training Requirements**

Parts of the certificate training requirements may be waived for those foster parents or back-up caregivers who are licensed health care professionals, such as pediatric nurses.

Such exceptions must be discussed and approved in writing by the FASU Program Manager and the Central Office Medically Complex Unit Nurses. The RRG Nurse may be consulted, as necessary.

The waiver must state:

- the specific training component(s) being waived; and
- the rationale for the waiver.

The FASU Program Manager shall ensure that a copy of the signed waiver is filed in the foster parent's record.

At a minimum, those persons granted a waiver shall complete the following requirements:

- the introductory lecture "Introduction to the Care of the Child with Complex Medical Needs;"
- age-appropriate CPR training;
- child-specific medical training; and
- child-specific mental health training including trauma and child traumatic stress.

The completion of the training shall be documented in LINK on the "Other Training" tab and in the case narrative

**Special Study, Relatives and Pre-adoptive Homes**

There are different post-licensing requirements for relative caregivers, special study homes, and pre-adoptive parents who intend to care for a specific child with complex medical needs. This is because medically complex certification is intended to provide a broad overview of conditions and care needs for all children with medically complex needs. Since relative caregivers, special study homes and pre-adoptive parents will only be caring for one specific child with specific needs, their training requirements only include topics relevant to those needs.

The required training for relatives, special study homes and pre-adoptive parents shall include the following:

- Medically Complex Pediatric Health (Module 11) or the pre-licensure "Fostering Health for Children in Foster Care" class;
- age-appropriate cardiopulmonary resuscitation (CPR);
- child-specific medical training; and
- child-specific mental health training including trauma and child traumatic stress.

All persons approved by DCF to care for a specific child with complex medical needs shall also be supported by a second individual who has received the same level of training. The second individual shall serve as a back-up to the primary caregiver For a detailed explanation of what is required to become a back-up, see "Qualifications for Backup Caregiver" in this Practice Guide.

**Special Study, Relatives and Pre-adoptive Homes (continued)**

The FASU Social Worker shall:

- make the final determination that the foster parent and the back-up caregiver have successfully completed all the required training; and
- enter information into LINK regarding the completion of training requirements.

**Medically Complex Certification Course**

The Medically Complex Certification Course consists of seven lectures**:**

1. Introduction to the Care of the Child with Complex Medical Needs
2. The Care of the Child with Respiratory Disease
3. The Care of the Child with Gastrointestinal Disorders
4. The Care of the Child with Neurological Disorders
5. The Care of the Premature Infant
6. The Care of the Child with Diabetes
7. The Care of the Child with Complex Medical Needs and Child Traumatic Stress: Ways to Minimize Trauma

For questions, please consult with your RRG Nurse or Central Office Medically Complex Unit Nurses.

**Medically Complex Foster Care Rate**

The rate for children with complex medical needs shall be used to provide reimbursement of costs incurred for those foster or adopted children who meet the complex medical needs criteria on an ongoing basis.

The rate for children with complex medical needs is different from the basic foster care rate.

**Initial Rate Approval**

In order to receive initial approval for a rate for complex medical needs, the child's Social Worker shall submit the DCF-2101,"Certification of a Child with Complex Medical Needs," to the RRG Nurse, Social Work Supervisor and Program Manager for their review and approval.

**Review of Status**

The child's complex medical needs status and rate shall be reviewed at the following times:

- at each Administrative Case Review and based on a review of the following information and documents:
  - the current DCF-2101;
  - the notes in the medical section of the record; and
  - the health forms in the child's Health Passport;
- whenever there is a change in the child's medical conditions; and
- during the biennial review of a subsidized adoption or guardianship case.

**Change in Rate**

Whenever there is a change in the child's medical condition which would cause a change in the rate, a new DCF-2101 must be signed by the primary health care provider and submitted for review and approval.

**Rate Amount**

The exceptional foster care supplemental payment is paid monthly and is determined by the medically complex classification of the child.

**Extraordinary Expenses**

Extraordinary expenses are for items, environmental adaptations, services or equipment which are ordered by the child's primary care provider for the child's care and which would result in an additional cost to the foster family.

These expenses include the rental or purchase of special medical supplies or equipment not provided through the child's medical insurance.

**Request for Extraordinary Expenses**

To request approval for extraordinary expenses, the child's Social Worker shall:

- consult with the Area Office Health Advocate;
- utilize the DCF-2103, "Extraordinary Expenses for the Care of a Child with Complex Medical Needs," to document the child's needs and all efforts to secure the needed resources through available funding sources; and
- submit the DCF-2103 to the Social Work Supervisor and Program Manager for review and approval.

**Respite Care**

Any person who wishes to provide respite care for children with complex medical needs in Classifications 2-4 must complete the:

- medically complex certification;
- age-appropriate CPR; and
- child-specific medical trainings.

Those wishing to provide respite care for children with complex medical needs in Classification 1 must complete:

- "Medically Complex Pediatric Health" (Module 11) or the PRIDE class "Fostering Health for Children in Foster Care;"
- age-appropriate CPR; and
- child-specific medical training.

## Termination of Pregnancy

**Introduction**

Connecticut law states that the decision to terminate a pregnancy shall be solely that of the pregnant woman in consultation with her doctor. The law requires youth under 16 years of age to receive specific pregnancy information and counseling from their health care providers before terminating a pregnancy.

Temporary caregivers, statutory, natural, foster and adoptive parents and guardians have no legal role in the decision and do not have to be consulted with or notified of the decision. DCF may assist young women by providing access to appropriate medical and counseling services.

**Legal reference:** Conn. Gen. Stat. §19a-600, §19a-601 and §19a-602.

**Definition**

**Counselor** means a psychiatrist, licensed psychologist, licensed clinical social worker, certified guidance counselor, certified marriage and family therapist, ordained member of the clergy, certified physician's assistant, licensed nurse-midwife, and licensed registered or practical nurse.

**Pregnancy Information and Counseling**

Pregnancy information and counseling prior to an abortion must be provided by a physician or counselor.

**Counseling Requirements**

Physicians and counselors shall:

- explain that the information is intended to neither persuade the young woman to have an abortion nor to carry the pregnancy to term;
- explain to the young woman that if she does decide to have an abortion, she can change her mind at any time before the abortion;
- explain that if she decides not to have an abortion, she can change her mind at any time during which she can have a legal abortion;
- explain the alternatives to having an abortion including informing the young woman of the possibility of having the child and keeping it, putting the child up for adoption, or placing the child with a relative or in foster care;
- inform the young woman that public and private agencies are available to assist her with the alternative she chooses and that she can have a list of these agencies and their services;
- explain to the young woman that she can get birth control information from public and private agencies and that she can have a list of these agencies;
- discuss with the young woman the possibility of involving her parents, guardian or other adult family members in her decision about the pregnancy;
- discuss with the young woman whether she thinks involving her parents or guardian would be in her best interests;
- give the young woman a chance to ask questions about pregnancy, abortion and child care; and
- give the young woman the information she wants or inform her where such information can be obtained.

**Affirming Receipt of Information and Counseling**

Following the receipt of information and counseling, the physician or counselor and the young woman must jointly sign and date a form attesting to the fact that the counseling requirements have been addressed to the satisfaction of the young woman. The physician or counselor's business address and telephone number must be included on the form.

**Counseling Forms and Counseling Services**

Counseling forms developed by the Department of Public Health (DPH) are available at health clinics under the jurisdiction of DPH. Counseling services, prior to an abortion, must be provided by counselors in those facilities.

**Emergency Exception**

Counseling procedures and forms are not required in medical emergencies that, for the young woman's safety or well-being, require an immediate abortion. A doctor performing such an abortion must indicate the medical emergency in the medical records.

**Religious Beliefs of Parents Preventing Necessary Medical or Mental Health Care**

**Requirement to Investigate**

A DCF investigator shall investigate reports alleging that a child is suspected of not receiving necessary medical or mental health care because of the religious beliefs of the parents or other caregivers when the child:

- is in a life-threatening condition;
- is suffering harm;
- is suffering pain;
- will suffer increased seriousness of a medical or mental health condition.

**Definition**

**Necessary health care** means medical, mental health or dental care that is not necessarily emergent but that would adversely affect the child's health if not provided within a reasonable time, as determined by a qualified medical provider.

**Medical Consultation**

The investigation shall include consultation with the medical or mental health providers who are treating the child and any other medical or mental health experts as needed to adequately investigate the case.

**Religious Consultation**

The investigation shall include developing an understanding of the religious beliefs relied upon by the parents or other caregiver for the denial of medical treatment, a discussion with the parents about those believes and, if approved by the parents, a consultation with their clergy or religious advisor about alternatives to treatment that are approved by the family's religion.

**Findings of Medical Neglect**

If medical neglect is substantiated, the investigator shall:

- work with the family to obtain permission for treatment if the child is not in a life-threatening condition; or
- file a Motion for Order of Temporary Custody immediately if the child is in a life-threatening condition.

Prior to filing an OTC, the investigator shall obtain affidavits from two physicians (which may include psychiatrists, if applicable) that describe the child's condition, the need for treatment, the urgency of the treatment and what would happen to the child if the treatment is delayed or denied and the parents' or caregiver's refusal to authorize treatment after being fully informed of the child's conditions and need for treatment.

**Procedures for Cases of Denial Based on Religious Beliefs**

Connecticut Practice Book §33a-8 sets out the procedure for obtaining an order from the Superior Court whenever there is an emergency life-threatening situation.

The investigator shall consult with the Area Office Attorney or Assistant Attorney General to determine the procedure to be followed.

**Jehovah's Witnesses' Refusal to Permit Blood Transfusions**

In a case in which the issue is the ability to obtain permission for a blood transfusion for a child who is a Jehovah's Witness, the investigator shall ascertain that:

- the parents or caregiver have denied permission based on religious beliefs;
- non-blood medical alternatives and treatment have been discussed between the parents and the caregiver and physicians;
- contact has been made with the Hospital Liaison Committee of Jehovah's Witnesses; and
- necessary medical care cannot be managed without a blood transfusion.

# Health Information and Documentation

## Medical Alert in LINK

**Introduction**

Each child in an out-of home placement, regardless of the child's legal status or Medicaid eligibility, shall have an up-to-date Medical Alert in LINK. It shall include information consistent with the "Health Passport Health Summary" (DCF-741HS) and shall be updated according to new information from providers including information on the DCF-742, "Report of Health Visit."

Health history that is not available at the time of placement shall be provided to the caregiver within 30 days of the date of placement.

**Purpose of Medical Alert in LINK**

The purpose of maintaining health information in the Medical Alert in LINK is to assist in the care, coordination and management of a child's medical and mental health care needs.

The medical and mental health content of the Health Passport is not intended as a substitute for the child's comprehensive health record.

**Who Completes the Medical Alert in LINK**

The child's Social Worker shall complete and update the Health Passport with the cooperation of the foster parents, relatives, the Social Work Supervisor, unit clerks, facility workers, RRG Nurses or Nurse Practitioners and medical and mental health care providers.

The Regional Resource Group (RRG) Nurse or Nurse Practitioner shall provide consultation in preparing and maintaining the health information in the Medical Alert in LINK.

## Health Passport

**Introduction**

Each child in an out-of-home placement, regardless of the child's legal status or Medicaid eligibility, shall have a Health Passport which has information necessary for the care of the child including:

- the child's medical and mental health history;
- exposure to traumatic events and the impact of trauma on functioning;
- current medical and mental health status; and
- the "Health Passport Health Summary" (DCF-741HS) or copy of the LINK Medical Alert.

The Health Passport shall be provided to the caregiver at the time of placement.

Health history that is not available at the time of placement shall be provided to the caregiver within 30 days of the date of placement.

**Purpose of Health Passport**

The purpose of maintaining health information in the Health Passport is to assist in the care, coordination and management of a child's medical and mental health care needs.

The medical and mental health content of the Health Passport is not intended as a substitute for the child's comprehensive health record.

**Who Completes the Health Passport**

The child's Social Worker shall complete and update the Health Passport with the cooperation of the foster parents, relatives, the Social Work Supervisor, unit clerks, facility workers, RRG Nurses or Nurse Practitioners and medical and mental health care providers.

The Regional Resource Group (RRG) Nurse or Nurse Practitioner shall provide consultation in preparing and maintaining the health information in the Portfolio. The Nurse or Nurse Practitioner shall be identified on the letter to health care providers to be included in the Portfolio. (See DCF-742-B, Instructions for Providers)

**Contents of the Health Passport**

The Health Passport shall include:

- a summary of current medical and mental health care issues contained on the DCF-741HS, "Health Passport Health Summary;" or a copy of the LINK Medical Alert;"
- documentation of any ongoing medical and mental health care as detailed on the DCF-742, "Report of Health Care Visit," along with five blank copies for future use;
- the DCF-2127, "Caregiver Log of Visits to Provider;"
- the child's Medical Identification Card;
- instructions to caregivers (DCF-742A); and
- instructions for medical and mental health care providers (DCF-742B).

**Health Passport Health Summary**

The Social Worker shall include the DCF-741HS, "Health Passport Health Summary" (or a copy of the LINK Medical Alert) in the child's Health Passport to provide health information to the caregivers that will immediately alert them and the health care provider of any potential health concerns for the child.

The DCF-741HS shall be updated according to new information from providers including information from the DCF-742, "Report of Health Visit." The updated copy of the DCF-741HS (or corresponding copy of the updated LINK Medical Alert) shall be provided to the caregiver. For example, allergic reactions to bee stings, medications, food or environmental factors should be immediately added to the DCF-741HS.

**Completion and Delivery**

The DCF Social Worker shall:

- complete the "Health Passport Health Summary" (DCF-741HS) and the Medical Profile in LINK with available information every time a child enters a new placement;
- provide a copy of the DCF-741HS to the caregiver at the time of placement as part of the child's Health Passport; and
- review the information on the DCF-741HS with the caregiver and answer any questions.

**Note:** A caregiver is defined as a person responsible for a child's care such as the child's guardian, foster or adoptive parent; an employee of a public or private residential home or facility; or other person legally responsible under state law for the child's welfare in a residential setting.

**Updates and Reviews**

The Social Worker shall:

- be responsible for all updates to LINK Medical Alert and the "Health Passport Health Summary" (DCF-741HS); and
- if there are any significant changes, provide an updated copy of the "Health Passport Health Summary" (DCF-741HS) to the caregiver to be filed in the child's Health Passport.

**Report of Health Care Visit**

The "Report of Health Care Visit" (DCF-742) shall be completed by the health care provider and utilized to document the child's ongoing medical and mental health care.

**Delivery of Five Copies**

The Social Worker who places the child shall include at least five blank copies of the DCF-742, "Report of Health Care Visit," (with the first two lines completed) in the Placement Portfolio which is given to the caregiver at the time of placement.

When additional forms are needed, the Social Worker shall supply them to the caregiver.

**Who Takes the DCF-742 to the Health Provider?**

When a child is taken to a medical or mental health care provider, the person who takes the child, whether it is the caregiver or the Social Worker, shall bring the child's Health Passport, including the DCF-742, to the provider.

**Responsibility for Completion**

At the time of placement, the DCF Social Worker or unit clerk shall complete the top two lines of the DCF-742 with identifying information for the child and Region, leaving the name of the DCF Social Worker blank if the child's Ongoing Services Social Worker has not yet been assigned.

At the time the child is taken to a medical or mental health care provider, the provider is responsible for filling out the rest of the form at the visit, if possible, and returning it to the caregiver or Social Worker.

If the child will have a series of sessions, such as for individual or group counseling, the medical or mental health care provider may note the frequency of contact on the initial DCF-742 and only fill out a new form for updates as needed.

**Provider Communication with Social Worker**

The caregiver shall contact the Social Worker or Social Work Supervisor immediately if the health care provider has indicated on the DCF-742 that he or she needs to speak to the Social Worker.

The health care provider shall also be encouraged to call the Social Worker with any questions or concerns.

**Documentation**

The caregiver shall place one copy of the DCF-742 completed by the medical or mental health care provider in the child's Health Passport and give the other copy to the Social Worker.

The Social Worker shall:

- file the DCF-742 in the medical section of the Uniform Case Record;
- note the occurrence of the medical or mental health visit in the LINK narrative;
- if necessary, update the LINK Medical Profile and the "Health Passport Health Summary" (DCF-741HS); and
- if the Social Worker has received the completed DCF-742 directly from the provider, give one copy to the caregiver.

**Review of DCF-742**

The Social Worker shall:

- review the completed copy of the DCF-742 for any important information;
- discuss the information with the caregiver to ensure that needed follow-up visits and continuity of ongoing care needs are met; and
- consult with the RRG Nurse if any information requires clarification.

**Substitute Documentation**

Substitute documentation for the DCF-742 may be submitted by medical or mental health care providers or by residential treatment facilities on their forms if the essential information is included.

The substitute documentation should be attached to a copy of the DCF-742 with the child's name on it and inserted in the Health Passport with a copy filed in the medical section of the Uniform Case Record.

**Immunization Records**

All children in DCF care will have up-to-date immunization records. The Social Worker shall maintain the immunization record with support from the RRG nurse. The immunization record shall be updated as needed based on all medical reports and DCF-742, "Report of Health Care Visit).

**Confidentiality**

The medical and mental health records of children are confidential and may only be shared with caregivers, health providers, school personnel and DCF staff personnel on an as-needed basis.

The Social Worker shall explain to the caregiver and child that no information found on these forms or records shall be shared with anyone without the consent of DCF.

**HIV/AIDS Status**

Information concerning a child's HIV and AIDS status may be released on an as-needed basis when DCF has legal guardianship.

When DCF does not have guardianship, a written release for disclosure of information from the parent or guardian must be obtained prior to any disclosure.

**Cross reference:** DCF Policy 26-3, "HIV Testing."

### Medical Questionnaire/Request for Medical Information

**Purpose**

Upon a child's entry into care, the intake Social Worker shall obtain a release of information from the child's parent or legal guardian and provide the "Request for Medical Information" (DCF-2147) to the child's medical provider.

## Securing Permission and Authorization of Specific Health Services

### Informed Consent

**Purpose**

It is the responsibility of DCF to ensure that informed consent is obtained before permitting health care treatment for a child in its custody.

**Note:** This policy does not apply to the involuntary administration of psychotropic medication. In such cases consult DCF Policy 44-5-2.2, Involuntary Administration of Psychotropic Medications.

**Definitions**

**"Assent"** means an expression of agreement or acceptance.

**"Emergency treatment"** or **"emergency care"** means medical or other medical or mental health treatment, services, products or accommodations provided to an injured or ill person for a sudden onset of a condition of such a nature that failure to render immediate care could:

- reasonably be expected to result in deterioration of the injured person's condition;
- reasonably be expected to result in a threat to the person's life, limb or sight; or
- cause the person to incur painful symptoms requiring immediate attention to relieve suffering.

**"Health care"** means medical, mental health or dental care, procedures and treatment.

**"Informed consent"** means permission given for a medical procedure or treatment after the parent or legal guardian, and the child when appropriate, has been provided with an explanation by a qualified health care provider which includes:

- the nature and seriousness of the diagnosis;
- the nature and length of the procedure or treatment;
- the type of anesthesia to be administered;
- the expected medical procedures, either before or during treatment, including physical exams, lab tests and EKG;
- the risks of the treatment or procedure;
- the expected benefits of the treatment or procedure;
- any reasonable alternative treatments, other than medication; and
- the possible common, long-term or infrequent side effects of any suggested medications which may be used in lieu of or in conjunction with the treatment or procedure.

**"Minor"** or **"child"** means any person under the age of 18 except where noted.

**"Necessary health care"** means medical, mental health or dental care that is not emergent but that would adversely affect the child's medical or mental health if not provided within a reasonable time, as determined by a qualified medical or mental health care provider.

**Definitions (continued)**

**"Qualified health care provider"** means a physician or other health care professional licensed by the Department of Public Health or accredited or certified to perform specified health services consistent with state law. Examples include, but are not limited to, the following:

- medical doctors including child and adolescent psychiatrists;
- doctors of osteopathy;
- psychologists;
- licensed clinical social workers;
- nurses;
- advanced practice registered nurses;
- physical therapists; and
- occupational therapists.

**"Routine care"** means well-child care in accordance with the Early and Periodic Screening and Diagnostic Treatment (EPSDT) service which focuses on health maintenance supervision, behavioral and developmental pediatrics and dental care, and includes routine health screenings to assess general health and to look for signs of health problems.

A primary health care provider providing routine care should ensure that the child is up-to-date with routine vaccinations and screening exams, which may include:

- check ups and tests;
- immunizations;
- assessment of health risks; and
- healthy lifestyle screening and counseling.

**Note:** For children with complex medical needs, routine care may include more extensive testing and evaluations.

**Forms**

The DCF-460, "Informed Consent for Necessary or Emergency Health Care or Referral" shall be used to provide informed consent for all necessary and emergency health care procedures and treatment, including specialty referrals and follow-up care. The DCF-460 shall be signed by the Commissioner or designee, or depending on the child's legal status, by the parent or guardian and provided to the health care provider by the Social Worker.

The DCF-460a, "Permission to Deliver or Obtain Routine Health Care," shall be used for permission for routine medical and mental health care. The Social Worker shall provide the foster parent or other DCF-authorized caregiver with the DCF-460a at the time of placement signed by the Social Worker or the child's parent or guardian, depending on the legal status of the child. The form authorizes the foster parent or other DCF-authorized caregiver to provide informed consent for routine health care. The DCF-460a shall expire when a child changes placement or 365 days after the date of signature.

The DCF-465, "Psychotropic Medication Consent Request," shall be used for informed consent to administer psychotropic medication.

**Forms (continued)**

The DCF-742, "Report of Health Care Visit," shall be filled out by the health care provider at each health care visit (medical, mental health, dental, etc.) and returned to the child's Social Worker.

In all cases, the health care provider is expected to provide sufficient information so that the person authorizing the health care can make an informed decision as to whether to provide consent for the procedure or treatment.

**Note:** Some health care providers may require that their institutional forms be signed in addition to the official DCF form. Whenever possible, these forms shall be reviewed by a DCF licensed health professional before providing informed consent to ensure that they comport with DCF medical requirements. DCF Social Workers shall confer with the RRG Nurse or Nurse Practitioner to review any non-DCF forms prior to signing, except forms related to the provision of psychiatric care.

**Social Worker Responsibility for Obtaining Proper Forms**

At the time of placement on a 96-hour hold, order of temporary custody, Family with Service Needs placement or Voluntary Services placement, the Social Worker shall request that a parent or legal guardian of the child sign the DCF-460a. The Social Worker shall provide this to the foster parent or other DCF-authorized caregiver so that the caregiver may access routine health care for the child.

If a child is subsequently committed to the Commissioner as a neglected, abused or uncared for child, the Social Worker shall provide the caregiver with a new DCF-460a signed by the Social Worker.

For necessary and emergency health care and the administration of psychotropic medications, the Social Worker shall prepare the relevant consent forms as outlined later in this policy.

**Requirements of Health Care Providers**

A health care provider is required to provide information to a patient and the patient's parent or legal guardian about the proposed treatment or procedure, consistent with his or her health care license, including the specifics of the proposed procedure or treatment, reasonably foreseeable risks, and the reasonable alternatives for care.

A health care provider is required by law to get the informed consent of the patient's parent or legal guardian before any procedure or treatment is provided and to show written evidence of that consent in the patient's medical record.

When age and developmentally appropriate, assent of a patient who is a minor is recommended and should be obtained whenever possible.

**Legal Status of Child and Consent**

The following chart indicates, according to the legal status of the child, who is responsible for providing consent for treatment.

**Note:** In some circumstances, as outlined later in this Practice Guide, minors may provide consent for health care treatment.

| Legal Status of Child | Who Can Give Consent |
|---|---|
| Voluntary Services Placement | Parent or Legal Guardian |
| Family with Service Needs Commitment | Parent or Legal Guardian |
| Delinquency Commitment | Parent or Legal Guardian |
| 96-Hour Hold | Parent or Legal Guardian |
| Order of Temporary Custody | Parent or Legal Guardian |
| Abuse, Neglect or Uncared-for (CPS) Commitment | DCF Commissioner or Designee |
| Dual Commitment (Delinquency and CPS running concurrently) | DCF Commissioner or Designee |
| Statutory Parent (Termination of Parental Right Granted) | DCF Commissioner or Designee |

**Authority to Provide Informed Consent**

The DCF designee shall not provide consent for any medical or mental health care for a child without first obtaining an explanation from the health care provider.

Informed consent for health care for a child in DCF custody shall be provided according to the child's legal status as outlined in the chart in the preceding section.

When consent is provided by DCF, such consent may be given by the Commissioner or designee. For routine health care, a foster parent or other DCF-authorized caregiver (such as a congregate care provider) may act as the Commissioner's designee.

**Responsibilities of the DCF Designee when DCF is not the Legal Guardian**

In any case in which DCF is not the legal guardian or statutory parent of a child in care, DCF shall make and document reasonable efforts to secure the informed consent of a parent or legal guardian prior to accessing health care.

If a parent or guardian is not reasonably available to provide or will not provide informed consent and the health care procedure or treatment cannot be delayed while DCF seeks a court order, DCF may provide informed consent following the procedure outlined in the preceding section of this policy.

**Responsibilities of the DCF Designee when DCF is not the Legal Guardian (continued)**

Circumstances in which DCF is not the legal guardian or statutory parent but the child is in DCF's physical custody include:

- child placed under a 96-hour hold;
- child placed under an Order of Temporary Custody (OTC);
- child placed pursuant to a Voluntary Services case;
- child placed pursuant to a delinquency commitment; and
- child placed pursuant to a Family With Service Needs case (FWSN).

Reasonable efforts to secure consent of the parent or guardian may include but are not limited to:

- attempting to locate a parent or legal guardian by telephone or in person;
- obtaining oral consent in lieu of written consent;
- communication with a parent's or legal guardian's attorney;
- sending a certified letter to a parent's or guardian's last known address;
- providing a parent or guardian with the name and telephone number of the qualified health care provider; and
- obtaining an interpreter where appropriate.

If DCF is unable to get permission from a parent or legal guardian, the Social Worker shall seek a court order prior to providing informed consent for any health care except routine health care. Routine health care may be accessed without a court order provided that reasonable efforts are made to secure the consent of a parent or guardian.

**Important Note About Emergencies:** Notwithstanding the general rules set forth above, emergency health care shall never be delayed because of the unavailability of a parent or legal guardian or insufficient time to access the court system. In any case in which the need for health care is emergent and there is insufficient time to get informed consent from a parent or legal guardian or a court order, the Commissioner or designee shall provide consent using the DCF-460. If a parent or legal guardian subsequently provides consent, a new DCF-460 shall be signed and shall replace the consent granted by DCF.

**Parental Denial or Rescission of Informed Consent**

A parent or legal guardian may object to health care for his or her child for any reason, including religious tenets, values or beliefs.

A parent or legal guardian may rescind and revoke any previously-given consent in writing.

If a parent or guardian objects to or revokes consent for health care, the Social Worker shall consult with the Area Office Attorney or Assistant Attorney General to determine if court action is necessary to obtain health care for the child.

**Cross reference:** DCF Policy 34-12-7, "Religious Beliefs of Parents Preventing Necessary Medical Care."

**Consent by Minor to Certain Health Care Services**

**Reproductive Health Services:** A minor may consent to reproductive health services, including:

- sexually transmitted disease (STD) testing and treatment;
- gynecological evaluation and treatment;
- abortion counseling; and
- services for pregnancy prevention.

The permission of a parent or legal guardian, including DCF, is not needed. However, a parent or legal guardian may provide informed consent, but the minor should assent.

**Legal reference:** Conn. Gen. Stat. § 19a-601.

**Out-patient Mental Health Treatment:** A minor may access up to six sessions of out-patient mental health treatment without parent or guardian consent when treatment is clinically indicated and when failure to provide treatment would be seriously detrimental to the child's well-being.

A mental health provider can, when in the interest of the child, provide more than six sessions without informing the parent or guardian if informing the parent or guardian may place the child at risk or if the parents or guardians are likely to deny additional treatment. The provider is required by law to document the reasons that treatment should continue and to re-evaluate the best interests of the child after every six sessions.

A parent or legal guardian may provide informed consent for out-patient mental health treatment, but the minor must also assent.

**Legal Reference:** Conn. Gen. Stat. §19a-14c.

**Voluntary Treatment in a Psychiatric Hospital:** Minors over the age of 14 **must** provide consent for voluntary treatment in a psychiatric hospital or mental health facility (unless involuntarily committed). Parental consent is not required, but parental notification within five days is required if the minor is age 14 or 15. Minors over the age of 14 may withdraw consent for voluntary treatment in a psychiatric hospital or mental health facility and may leave the hospital or facility unless involuntary commitment proceedings are begun.

**Legal Reference:** Conn. Gen. Stat. §17a-81.

**Drug and Alcohol Treatment:** Children under the age of 18 may consent to alcohol or drug treatment. Parental consent is not required.

**Legal Reference:** Conn. Gen. Stat. §17a-688(d).

## Psychotropic Medications Approval

**Monitoring of and Consent to Prescribe**

Medical oversight of the consent to and monitoring of psychotropic medication is required by state law.

DCF has established a centralized mechanism, via a computerized database, to quantify the use of psychotropic medications for children committed to DCF. This database contains all requests, the class of medication, the setting and the decisions made regarding those requests.

The following Practice Guide sections provide a streamlined process through which providers may interact directly with DCF medical and nursing staff who are trained and board certified in psychiatric and behavioral health care.

**Legal reference:** Conn. Gen. Stat. §17a-21a.

**Introduction**

DCF requires that prescribing practitioners obtain appropriate informed consent regarding a child in the care of DCF who requires medically-necessary psychotropic medication.

DCF shall make available to practitioners treating children in the care of DCF a copy of the DCF "Guidelines for Psychotropic Medication Use for Children and Adolescents."

**Definitions**

**"Assent"** means agreement with the medication being prescribed and is required for all youth ages 14 and up. It is the responsibility of the prescriber to document assent and also the risks and benefits of the proposed medication in the medical records.

**"CMCU APRN"** means an Advanced Practice Registered Nurse who serves as the Commissioner's designee in reviewing and approving the use of psychotropic medications.

**"Centralized Medication Consent Unit" or "CMCU"** means a centralized unit that is responsible for the receipt, triage, communication, data collection and decision-making processes used to provide consent to treat children with psychotropic medications. The CMCU is staffed by psychiatric nurses and child psychiatrists, who have been designated by the Commissioner to provide consent for psychotropic medication requests.

**"Chief of Psychiatry"** means the child and adolescent psychiatrist who is responsible for oversight of the Regional Medical Directors and the Centralized Medication Consent Unit.

**"Designee,"** as used in this section, means a representative of the Commissioner who has been given authority to review and provide consent for psychotropic medications. Designees are the Chief of Psychiatry, Regional Medical Directors, CMCU Nursing Staff, Careline staff and senior medical staff who are on call after hours.

**Definitions (continued)**

**"Informed consent"** means permission granted by a child's guardian to prescribe psychotropic medication. As part of the consent process, the prescriber shall provide the patient or the patient's representative with the following:

- the nature and seriousness of the diagnosis;
- the nature of the medication;
- the risks of the medication;
- the expected benefits of the medication;
- any reasonable alternative treatments other than medication; and
- the possible common, long-term or infrequent side effects of the medication.

**"Non-business hours"** means Monday through Friday after 5:00 PM, weekends, state holidays**,** and other times when normal day-to-day business is not being conducted.

**"Psychotropic medications"** means medications prescribed for psychiatric purposes that affect the central nervous system and influence thought processes, emotions and behaviors.

**"Reasonable efforts (to gain consent)"** means the strategies employed by DCF staff to contact and inform a child's parent or guardian, and to inform a child over the age of 14, of the reason for the psychotropic medication and the risks and benefits of the administration of the psychotropic medication. What is "reasonable" depends on the circumstances of the case, including time of day, the condition of the child, whether the child will suffer serious physical or mental harm if administration of medication is delayed and the availability of a parent or guardian. "Reasonable efforts" include, but are not limited to, telephone calls or in-person visits to any person who is likely to know how to contact a parent or guardian.

**"Regional Medical Director"** means a child and adolescent psychiatrist assigned to designated regions, each consisting of a grouping of DCF Area Offices. The Regional Medical Director may act as the Commissioner's designee for purposes of the medication approval process.

**"Request for Review"** means a request made by a provider to the Chief of Psychiatry to review and, if appropriate, overturn the denial of a medication request by a medical designee.

**"Timely manner"** means the expected time frame to obtain consent for medication treatment. Whenever possible, requests shall be processed within one business day. Requests that require consultation with the provider or contain insufficient information may not be completed within that timeframe.

**Forms**

**DCF-465** - The "Psychotropic Medication Consent Request" must be submitted by the provider for each request to prescribe a psychotropic medication. The final outcome of the request is also recorded on the DCF-465 by the Regional Medical Director or CMCU APRN and a copy is returned to the prescribing provider.

**DCF 465A** – The "Notification – Discontinuation of a Psychotropic Medication" must be completed by the prescribing provider whenever discontinuing a psychotropic medication for which consent has been previously received.

**DCF 465B** – The "Suspected Adverse Drug Reaction Reporting Form" must be submitted to the CMCU by the prescriber whenever a child has or is suspected of having an adverse reaction to a psychotropic medication.

**Protocols for Consent**

The DCF Commissioner or designee shall make a determination regarding the use of psychotropic medication in a timely manner, consistent with the best interests of the child.

A Regional Medical Director or a CMCU APRN shall review each request for the use of psychotropic medication prior to making a determination regarding consent.

**Requests for Review**

A Request for Review may be submitted to the Chief of Psychiatry:

- when the prescribing provider disagrees with a DCF designee's denial of consent to prescribe a psychotropic medication; or
- when requested by the DCF Commissioner, a DCF Regional Administrator or a DCF Facility Superintendent.

**Responsibilities of the Centralized Medication Consent Unit**

The Centralized Medication Consent Unit (CMCU) shall ensure that requests for consent to prescribe psychotropic medications are received and reviewed and final decisions are sent to the prescribing providers in a timely manner as follows:

- the CMCU shall accept medication requests from the prescribing provider on the DCF-465;
- the CMCU shall verify the child's demographic information, assigned Area Office and legal status in LINK;
- based on the child's legal status, the CMCU shall determine the steps necessary to make a decision regarding the medication request; and
- the CMCU shall triage and communicate appropriate decisions regarding each medication request.

**Legal Status of Child and Consent**

The following chart indicates, according to the legal status of the child, who may provide informed consent.

| Legal Status of Child | Who May Give Consent |
|---|---|
| Voluntary Services Placement | Parent or Legal Guardian |
| Family with Service Needs Commitment | Parent or Legal Guardian |
| Delinquency Commitment (see below for special instructions) | DCF Commissioner (see below for special instructions) |
| 96-Hour Hold | Parent or Legal Guardian |
| Order of Temporary Custody | Parent or Legal Guardian |
| Abuse, Neglect or Uncared for (CPS) Commitment | DCF Commissioner or Designee |
| Dual Commitment (Delinquency and CPS running concurrently) | DCF Commissioner or Designee |
| Statutory Parent (Termination of Parental Rights Granted) | DCF Commissioner or Designee |

**Child Whose Legal Status Requires Parental Consent**

For any child whose legal status requires parent or guardian consent, the Social Worker shall make reasonable efforts to obtain the informed consent of the child's parent or guardian, and the child if he or she is over 14 years of age.

If the parent or guardian is not available to provide consent, the Social Worker shall:

- ensure that the child is provided with all necessary medical care, which may include an examination by a physician or mental health professional;
- consult with an Area Office Attorney or Assistant Attorney General for further advice regarding reasonable efforts to obtain consent, potential court proceedings to obtain judicial authorization and any other legal issues that may arise;
- when appropriate, seek a court order authorizing the use of psychotropic medication; and
- document all efforts to gain informed consent from a parent or guardian, and a child over 14 years of age, as well as any refusals.

**Note:** A physician may authorize emergency medical care without the consent of a parent or guardian while the Social Worker continues to make reasonable efforts to inform the parent or guardian. The authorization for treatment during an emergency shall last only as long as the emergency exists.

**Note:** For after-hours emergencies, consultation with a DCF legal manager is recommended, but not required. However, legal staff shall be consulted the next business day following the after-hours emergency.

**Child whose Legal Status Permits DCF Consent**

In the case of a child whose legal status permits DCF to provide consent, the CMCU shall:

- enter the medication consent request, and all information related to the medication request, in the computerized database;
- review the medication consent request;
- if additional information is required, request information from the Area Office Social Worker, the RRG Nurse or the provider;
- make and enter the decision into the computerized database and document in LINK the reasons for any denials;
- fax or email the finalized DCF-465 to the prescribing provider; and
- send notification of the final outcome to the CMCU, Regional Clinical Manager, Area Office Social Worker and RRG nurse.

**Children Committed Delinquent**

In the case of a child who has been committed to DCF as a delinquent, the Commissioner or designee may authorize medical treatment, including medication, of the child without the consent of the parent or guardian as long as DCF makes reasonable efforts to inform a parent or guardian of the need for treatment prior to the treatment being administered.

Following treatment, DCF shall notify a parent or legal guardian in writing of the treatment provided, the necessity for the treatment and the outcome of the treatment.

**Legal reference:** Conn. Gen. Stat. §17a-10(c).

**Protocol for Non-Business Hours**

The Careline Social Work Supervisor shall ensure that reasonable efforts are made to gain consent for administration of medication from the parent or guardian of a child whose legal status so requires.

When DCF is the legal guardian, the Careline Social Work Supervisor shall determine whether the request is an urgent request to start a new medication. If so, the Careline Supervisor will ensure that:

- the requesting prescriber has faxed or emailed a completed DCF-465 to Careline;
- all pertinent and available information regarding the child is gathered prior to contacting the on-call DCF physician; and
- the DCF on-call physician is consulted regarding all new urgent consent requests for psychotropic medication made during non-business hours.

When an after-hours psychotropic medication request to start a new medication is not urgent, the Careline Social Work Supervisor shall inform the prescriber that:

- the DCF-465 should be submitted for processing the following business day;
- all requests to continue previously prescribed medication shall also be processed by the CMCU the following business day; and
- current medications without any changes may be continued until the new request is reviewed by the CMCU the next business day.

**Notification of Discontinuation of Psychotropic Medication**

The prescribing provider is expected to notify DCF whenever discontinuing a psychotropic medication. Notification may be part of other changes already requested on a new DCF-465. However, if the discontinuation is the only change, notification to DCF must be made by faxing or emailing the DCF-465A to the CMCU APRN.

**Note:** While the prescribing provider is not required to seek informed consent for discontinuation of a medication, the child's parent or guardian and the child, if appropriate, shall be informed of the decision and the reasons, as soon as practical, by the provider or DCF.

The CMCU shall:

- receive the DCF-465A notification form;
- enter the information in the computerized database and in LINK; and
- send notification of the medication discontinuation to the Area Office Social Worker.

**Provider Request for Review**

A prescribing provider may submit a Request for Review to overturn a denial made by a CMCU designee.

A review of the decision of a CMCU designee shall be assessed by the Chief of Psychiatry and the decision of the Chief of Psychiatry shall be final.

The CMCU shall:

- record the Request for Review and final outcome in the database and in LINK; and
- send notification of the final decision to the provider and to the Area Office staff.

**Adverse Drug Reaction**

The prescribing provider must submit the DCF-465B whenever there is a known or suspected adverse drug reaction to a psychotropic medication.

A complete description of signs and symptoms of the adverse reaction, along with treatment received, must be submitted on DCF-465B for CMCU collection and review.

## Involuntary Administration of Psychotropic Medication

**Purpose**

The decision to administer involuntary psychotropic medication to a child in non-emergency situations requires weighing the child's right to refuse psychiatric medications against the need to provide necessary treatment to a child with a serious mental disorder. DCF has defined a process that utilizes professional clinical judgment and practice standards to make decisions regarding involuntary psychotropic medications that are then presented to the Superior Court for an independent judicial determination of the necessity for the medication.

**Background**

Involuntary medication treatment by its nature is controversial. When someone considered to be mentally ill disagrees with an assessment of his or her medication needs, the right to refuse medication is sometimes challenged by the treatment provider on the grounds that the illness has robbed the person of the ability to understand the condition and to make appropriate decisions about treatment.

Patients older than age 14 and their parents or guardians have the right, in most cases, to refuse to consent and they must be taken seriously when they express concerns about the need for or the psychological and physical effects of medications.

Pursuant to Conn. Gen. Stat. §17a-543, "No patient shall receive medication for the treatment of the psychiatric disabilities of such patient without the informed consent of such patient, except in accordance with [statutory] procedures …."

Conn. Gen. Stat. §17a-540(8) defines **"informed consent"** as "permission given competently and voluntarily after a patient has been informed of the reason for treatment, the nature of the proposed treatment, the advantages or disadvantages of the treatment, medically acceptable alternative treatment, the risks associated with receiving the proposed treatment and the risk of no treatment."

The use of involuntary medication, administered against a patient's, parent's or guardian's wishes, shall be fully discussed with all treatment team members, with the child, with parents or guardians, with the Area Office Social Work staff and with legal representatives for the child, parents and guardians.

**Emergency Administration of Involuntary Medication**

Involuntary medication may be administered to a child in an emergency situation.

**"Emergency situation"** means the circumstance in which a physician determines that treatment, including medication, is necessary to prevent serious harm to a child.

Such emergency treatment may be administered pending receipt of or in the absence of parental consent, for only so long as the emergency lasts.

**Legal reference:** Conn. Gen. Stat. §17a-81

**Non-Emergency Medication of Uncommitted Children**

DCF shall not consider the non-emergency involuntary administration of psychotropic medications to an uncommitted child unless the child is a patient at Albert J. Solnit Psychiatric Hospital.

If the patient is younger than age 14, written consent to administer psychotropic medication is required only from the parent or guardian.

If the patient is age 14 or over, written consent must also be obtained from the child.

**Non-Emergency Medication of Uncommitted Children (continued)**

If written consent is requested from the patient or patient's parent or guardian, the DCF attending physician shall review with the patient and the parent or guardian:

- the risks and benefits of the psychotropic medication;
- side effects from the medication;
- the preferences of the patient;
- the patient's religious and cultural views about the medication; and
- the prognosis with and without the medication.

In a case in which

- the parent or guardian refuses to consent to medication,

**or**

- the patient, regardless of age, refuses to take the medication,

**and**

- the patient is sufficiently ill that the DCF attending physician believes that the administration of the medication is medically necessary and in the best interest of the patient,

the DCF physician shall request a second opinion by a child and adolescent psychiatrist not employed by DCF regarding the need for medication. The DCF attending physician shall also notify the Solnit Medical Director and the DCF Medical Director.

If the independent child and adolescent psychiatrist is in agreement regarding the need for medication, and the DCF Medical Director concurs with the DCF attending physician, Solnit medical staff shall apply to the DCF Medical Review Board for a recommendation.

If the DCF Medical Review Board recommends involuntary medication, Solnit staff shall then contact the DCF Office of Legal Affairs for a legal consultation. If the decision is made to proceed with court action, the Office of Legal Affairs shall contact the Office of the Attorney General to initiate an application to the appropriate court for a court order for the involuntary administration of psychotropic medication against the parent's or patient's wishes.

If there is disagreement among the physicians consulted as to the necessity for involuntary medication, a court order will not be pursued.

If there is agreement between the attending physician and the independent physician, but the Agency Medical Director or the Medical Review Board disagrees, then the DCF Commissioner shall make the final decision whether or not to seek a court order for involuntary medication administration.

**Administration of Psychotropic Medication to Committed Children**

Providers caring for children under the guardianship of DCF shall request consent for psychotropic medication administration from the DCF Central Medication Consent Unit.

A DCF physician shall review with the patient and, where appropriate, the parent:

- the risks and benefits from the medication;
- side effects from the medication;
- the preferences of the patient;
- the patient's religious and cultural views about the medication; and
- the prognosis with and without the medication.

In cases in which consent is obtained from the Central Medication Consent Unit but the patient, regardless of age, refuses to take the prescribed medication, and the patient is sufficiently ill that a DCF physician reasonably believes the administration of the medication is medically necessary and in the best interest of the patient, the DCF physician shall immediately notify the Area Office Social Worker and, additionally, shall request a second opinion by a child and adolescent psychiatrist not employed by DCF. The DCF physician shall also notify the facility Medical Director, if applicable, and the DCF Agency Medical Director.

If the independent child and adolescent psychiatrist, the DCF Medical Directors and the DCF physician are all in agreement that the medication should be administered involuntarily, the recommendation of the DCF Medical Review Board shall be sought.

If the Medical Review Board also recommends involuntary administration, the DCF medical staff and the Area Office Social Worker shall consult with the DCF Office of Legal Affairs. If the decision is made to seek a court order, the Office of Legal Affairs shall contact the Office of the Attorney General to initiate an application to the appropriate court for a court order for the involuntary administration of psychotropic medication against the patient's wishes.

If there is disagreement between the independent psychiatrist and the DCF physician, a court order will not be pursued. If there is agreement between the physicians, but disagreement by the Medical Review Board or the Agency Medical Director, the Commissioner shall make the final decision as to whether to seek a court order for involuntary medication administration.

**Documentation for Court Action**

When the decision has been made to seek a court order to administer medication involuntarily, the Area Office Social Worker and the DCF medical staff, with the assistance of the DCF Office of Legal Affairs and the Office of the Attorney General, shall collaborate to submit to the court, in support of the motion, affidavits and other documentation sufficient for the court to determine whether:

- the proposed medication is in the best interests of the patient; and
- there is no less intrusive course of treatment available.

The affidavits and documentation submitted shall include, at a minimum, the following information:

- an explanation of the patient's diagnosis and prognosis, or his or her predominant symptoms, with and without the medication;
- information about the proposed medication, its purpose, the method of its administration, the recommended range of dosages, possible side effects and benefits, ways to treat side effects, and risks of other conditions such as tardive dyskinesia;
- a review of the patient's history, including medication history and previous side effects from medication;
- an explanation of interactions with other drugs including over-the-counter drugs, street drugs and alcohol; and
- information about alternative treatments and their risks, side effects and benefits including the risks of no treatment.